SOCIAL SERVICES
INSPECTORATE

Social Services Inspectorate
Floor 3, 94 St. Stephens Green, Dublin 2
Tel: (01) 418 0588 Fax: (01) 418 0829
Email: ssiinfo@health.irlgov.ie
Web: www.issi.ie

Foireann Chigireachta Sheirbhísí Shóisialta
Úrlár 3, 94 Faicha Stíofáin, Baile Átha Cliath 2
Teil: (01) 418 0588 Facs: (01) 418 0829

SOCIAL SERVICES
INSPECTORATE

annual report

Social Services Inspectorate 2001

annual report

Social Services Inspectorate 2001

Contents

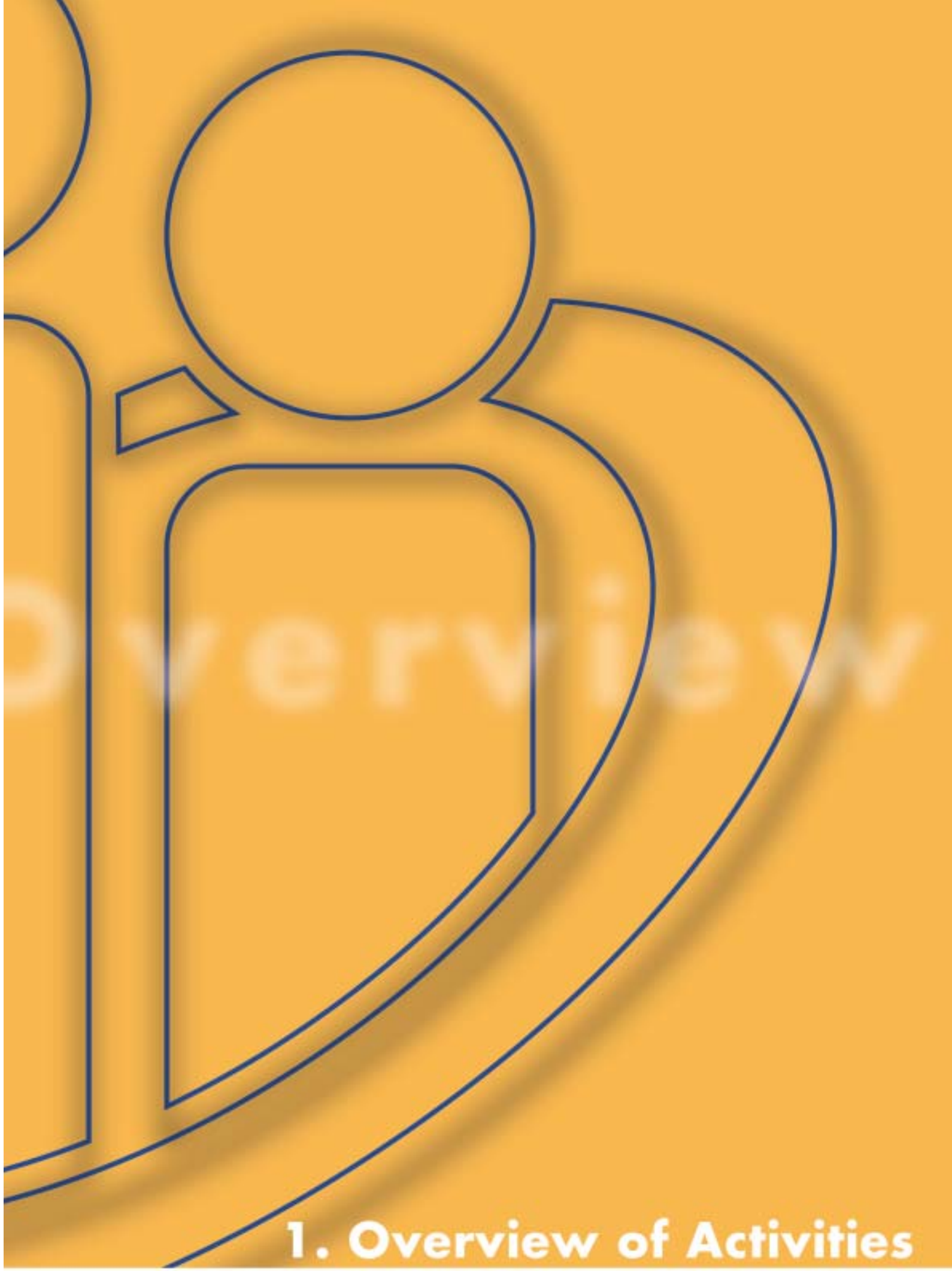
Introduction

This is the first annual report from the Social Services Inspectorate. In October 2000 Report on Findings Relating to the Inspection of Children's Residential Centres (commonly referred to as the Overview Report) was published. It consisted of findings and recommendations of the first 12 inspections of children's residential centres.

The aim of this report is to give an account of our activities over the past year, and to report on findings from 23 inspections that took place between July 2000 and July 2001 to the Minister, health boards, other providers of children's services and the public. The report will summarise our main findings and indicate areas that need attention in the coming year. It will also lay out SSI's work plan for next year.

There have been changes in personnel in the past year. Victor McElfatrick, acting Chief Inspector from the inception of SSI, on secondment from the Social Services Inspectorate, Northern Ireland, returned to his full time post in Belfast in April 2001. SSI is indebted to him for his work in establishing the Inspectorate and its early development. The office now consists of a full time Chief Inspector, four inspectors and an office administrator.

The overall aim of SSI is to inspect social services against agreed standards and support developments that will help these standards to be met. This is done by inspection, advice to the Minister, input to government development of standards and child care policy, contribution to practice guidelines, research and training and disseminating findings. Although inspection can be an intense and rigorous experience for health board managers and professional staff alike, it is intended to act as a catalyst for improvement. It does this by making specific recommendations for change where necessary, and by encouraging agencies to develop a greater aptitude for self-assessment and resolve limitations in advance of inspection. Additionally, published inspection reports highlight reasons why services do well or are lacking and this serves to inform other services and professionals of appropriate standards and practice.



1. Overview of Activities

1. Overview of Activities

1.1 Authority of the Inspectorate

The authority of SSI is derived from the Child Care Act 1991 Section 69, which states that 'The Minister may cause to be inspected any service provided or premises maintained by a health board under this Act'.

Although administered by the Department of Health and Children (DoHC), the inspectorate functions independently. The recently published Health Strategy has stated that SSI will be established on a statutory basis and that its remit will extend to the areas of disability and services for older people.

1.2 Inspection of Children's Residential Centres

The main activity of SSI has been inspection of children's residential centres. Since the Inspectorate was established, 39 inspections of children's residential centres have been undertaken. The findings of the first 12 were summarized in the 'Report of Findings Relating to Inspection of Children's Residential Centres' published in October 2000. The current report comments on the findings of the 23 inspections completed between July 2000 and July 2001. The findings on the remaining four centres inspected in the autumn of 2001, but awaiting their final reports, are not included in this report. All the centres referred to in this report were inspected against the Draft National Standards for Children's Residential Centres, now replaced by the National Standards of Children's Residential Centres (published September 2001). Following inspection, two centres relocated to suitable premises on the recommendation of the inspectors in relation to fire safety and a further two centres closed

To date all inspections have been announced. Health boards are given six weeks notice of a forthcoming inspection. Two inspectors usually undertake inspections. Boards are required to supply information concerning staff, children, fire and insurance certificates and specific care practices prior to the field work. Inspectors write to children, parents or guardians, social workers, teachers and other professionals and invite them to take part in the inspection. Fieldwork takes place over three days and inspectors interview staff, managers, children, parents, social workers and others. Additionally, they review case files and administrative records and observe care practices. A draft report is sent for factual accuracy to the centre. The final report is made available and is posted on our website, (www.issi.ie). Children and young people are sent a summarised report with the main findings.

SSI completed a cluster inspection of all children's residential services within the North Eastern Health Board (NEHB) and is undertaking a second cluster within the Southern Health Board (SHB) Kerry Community Care Area. During a cluster all children's residential centres are inspected to the same standard by the same process as individual inspections. But reviewing all centres simultaneously also allows for an overview of strategic planning and common themes to be incorporated.

SSI inspects special care units on an annual basis and to date has inspected one special care unit twice and the second unit once. It is the intention of the Inspectorate to continue this regularity of inspecting special care units.

1.3 Monitoring the implementation of Children First

One of the inspectors has a monitoring function on the implementation of Children First, National Guidelines for the Welfare and Protection of Children (1999). Over eighteen months this inspector visited each health board and had a number of meetings with the national implementation advisory group and the Health Boards Executive (HeBE) implementation support team. He has found the pace of implementation of Children First has been uneven across health boards. There are a number of reasons for this. First, different health boards have traditionally approached child protection in different ways: some use a uni-disciplinary approach (with responsibility for child protection mainly a social work one) while others a multi-disciplinary approach (responsibility shared with

other disciplines). Those with multi-disciplinary systems already in place have less to do to bring their system into conformity with Children First. Second, some boards have experienced considerable difficulty in recruiting staff to facilitate the implementation process. Third, there have been some differences of interpretation of Children First and confusion in relation to the purpose and operation of the Child Protection Notification System (CPNS), and some boards have decided not to implement this aspect of Children First until the issues have been clarified. A report of this stage of the monitoring exercise will be published on our website in early 2002.

1.4 Standards

A priority of SSI is the development of agreed standards against which a service is inspected. These standards, when published, are government policy and state what is expected in all aspects of the service, and they clearly outline how a service is going to be judged. The standards are based on legislation, government regulation, best practice and research findings here and abroad. Additionally, they are informed by international conventions ratified by the state, such as the UN Convention on the Rights of the Child.

It is the aim of SSI that government standards have a broader function than setting the criterion against which inspections will occur. Agreed, written standards are helpful for providers and users of a service. They state explicitly what is expected in all aspects of the service and the criteria outline how this standard can be both reached and measured. This encourages a dialogue by manager, staff and clients about the service that is provided. Standards also clearly state what service users and their families may expect and provides a framework for discussion with service providers about the quality of the service.

1.4.1 National Standards for Children's Residential Centres

SSI was pleased to contribute to the development of these standards, published by the Minister for Children, Mary Hanafin,T.D.in September 2001. National Standards, apply to all community based centres and high support units managed in both the health board and non-statutory sector across the country.

1.4.2 National Standards for Special Care

The DoHC, in consultation with a wide range of interested parties, developed national standards for special care and these were issued by the DoHC in November 2001. SSI piloted these as draft standards when inspecting two special care units during June and July 2001.

1.4.3 Foster Care Standards

The DoHC established a Foster Care Standards Group in September 2001. The group has representatives of the DoHC, SSI, health boards, Irish Association of Foster Carers, SSI Northern Ireland and the Daughters of Charity. The group hopes to produce a draft standards document for consultation in mid 2002.

1.4.4 Standards in other social services.

SSI has met with various groups representing service providers, service users and other interested parties to support the development of statements of quality assurance and standards for their own services. General interest has been expressed in the area of standards by a wide range of bodies, and in advance of national standards being developed SSI recommends that organisations develop, in partnership with service users, standards that encourage the delivery of high quality services.

1.5 Information about SSI and practice guidance

Prior to SSI starting inspections, the DoHC and SSI visited all health boards and met key personnel to describe the work of the office and explain the inspection process. In January 2001 a website was set up which described the inspection process and published inspection reports. In September, a hard copy information booklet and separate leaflets was published outlining the inspection process of children's residential centres for staff teams, children in

residence and parents or guardians of children living in the centre. These documents accompany letters to children and their families telling them of an upcoming inspection and inviting them to meet with inspectors.

SSI understands part of its function as being to offer periodic advice and guidance to service providers. In response to requests for advice from health board managers as a support to implementing inspection reports, inspectors developed guidance notes on four subjects this year: safeguarding issues in children's residential centres; complaint's procedures; consulting with children and access to information. SSI plans to extend guidance notes to other key areas, and in time, to publish them as complete guidance notes to accompany the standards.

All of the above booklets, leaflets and guidance notes are available from our office and are posted on our website.

1.6 Unaccompanied children seeking asylum

The attention of the Inspectorate has been drawn to the placement of unaccompanied children seeking asylum in residential and hostel care. Under Section 8(4) of the Refugee Act,1996, such children are dealt with under the Child Care Act 1991. The Inspectorate has not inspected any residential or hostel accommodation (but has inspected a hosted where some unaccompanied children were placed with homeless young people) to date but has been asked by health board managers to give advice regarding standards of care. This is mainly, but not exclusively, an issue for the three boards within the Eastern Regional Health Authority (ERHA). In practice, the children and young people are assessed on the day of referral by a specialist team acting for the three boards and are either reunited with their families in this country, or placed in foster care, a children's residential centres or a hostel. Children not returned to their families are generally in the care of the board.

The numbers of unaccompanied children seeking asylum children has grown substantially over the past two years. In 1999 there were 98 unaccompanied minors in total and in 2000 there were 517. Between January and July of 2001 730 applications were made under Section 8 of the Refugee Act 1996.

In September 2001 figures released by the team working with unaccompanied children stated that ten children were placed with families, four in children's residential centres and 408 in hostels. The majority of this group are 17 years old and 38 were accommodated in a hostel designated for older teenagers (17 years and over). The remaining 370, of whom 18 were in the 14 to 15 year age group, were placed in adult hostels.

The standards of care for these children and young people in the care of the boards should be of a level that ensures their needs are adequately met. Of concern are the younger group of 14 and 15 year olds placed in adult hostels. It is rarely appropriate for young people of this age to find themselves in an adult hostel. The Inspectorate is aware that occasionally a child as young as 11 years may be placed in an adult hostel to keep them with an older teenage sibling. Social workers or project workers are allocated to these young people and refer them to schools or other appropriate services. However the children shop and cook for themselves and spend their leisure time unsupervised and unsupported.

The three health boards within the ERHA region state they are reviewing these services and other reception and assessment options are being considered. SSI welcomes such an appraisal and looks forward to supporting boards in developing services for all unaccompanied asylum-seeking children.

1.7 Contribution to conferences and training and working groups

Members of the Inspectorate have contributed to conferences and training throughout the year. Amongst these was the conference on Best Practice in Residential Child Care held in September. Additionally, the Inspectorate contributed to the Annual Conference of the National Association of Mentally Handicapped in Ireland (NAMHI) and to in-service training in health boards. The Inspectorate also made presentations to final year social work students in UCD and TCD, and plans to do presentations to the institutes and colleges preparing students for work in the area of social care.

1.8 Publication of reports

In supporting the development of quality social services SSI is keenly aware that the experience of the service user is central to its findings. Additionally the public have to have confidence in the Inspectorate's work. In order to achieve this they need to have access to published reports and to the inspection process. The principle of access to published reports should never put at risk the confidentiality and respect due to individual children and their families. Reports of service should be fair and balanced, and where appropriate, should include the context within which the services are operating. From time to time a report may not be published if identifying information regarding a child or young person cannot be sufficiently disguised to guarantee their anonymity.

One health board made written representations to SSI, and some others did so verbally, regarding their concern that identifying the location of a centre had negative implications for young people living in these. SSI consulted informally on this issue, including the Irish Association of Young People in Care (IAYPC) and, as a result, we reviewed our procedures. It was decided in the interests of young people that the full address of community-based children's residential centres would no longer be published. However, SSI is aware that many centres have no name and are referred to on the basis of their address. It is the Inspectorate's intention that reports identify the centre that has been inspected without revealing its exact location. SSI does not want to put the safety of children living in children's residential centres at risk by identifying their location alongside possible shortcomings of the centre identified in the report, or indeed to jeopardise its position within its neighbourhood. In the short term SSI has published a small number of reports of centres that have no name stating only the community care area and health board in which they are located. However, all children's residential centres are now requested to have a name by which they are known. This name should not refer to the street or area in which they are located.

It is the aim of SSI that in addition to being publicly accountable, the publication of reports should assist service providers, students and others in understanding more fully the complete range of residential services available in the country and help them in identifying best practice and how this is achieved. Encouragingly, positive feedback has been received from many sources in this regard.

1.9 Research in children's residential centres

SSI fully supports research initiatives that provide better information about the lives of children living in residential care. We are aware of an increased number of students undertaking research as part of their studies and other research projects proposed in the area of child care. It is possible that some children could find themselves subject to multiple research studies. Some providers of residential care have sought advice on how to manage such requests. We recommend that the interested parties in the area should agree ethical and process issues for research with young people in care. Individual young people should not be exposed to excessive or intrusive demands even if the research generates benefits for young people in care as a whole.

2.Numbers and Types of Children's Residential Centres

2. Numbers and Types of Children's Residential Centres

This chapter outlines the number and type of children's residential centres in the statutory and non-statutory sectors. The accuracy of this information has been affected by changing definitions of purpose and function, new developments of special arrangements, emergency provision and transfer of management. The information below reflects returns made to SSI. Greater accuracy of such information is one of the aims of our office.

2.1 Number of children's residential centres per health board area in the statutory and non-statutory sector

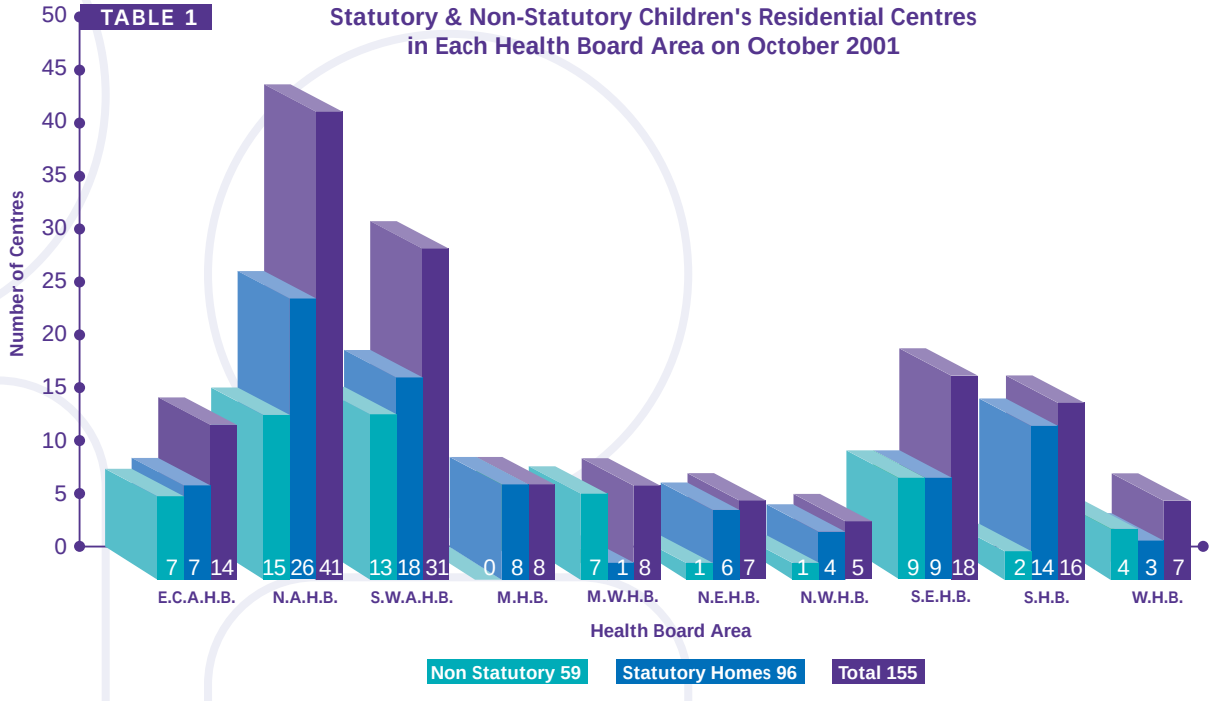
Reference: Table 1

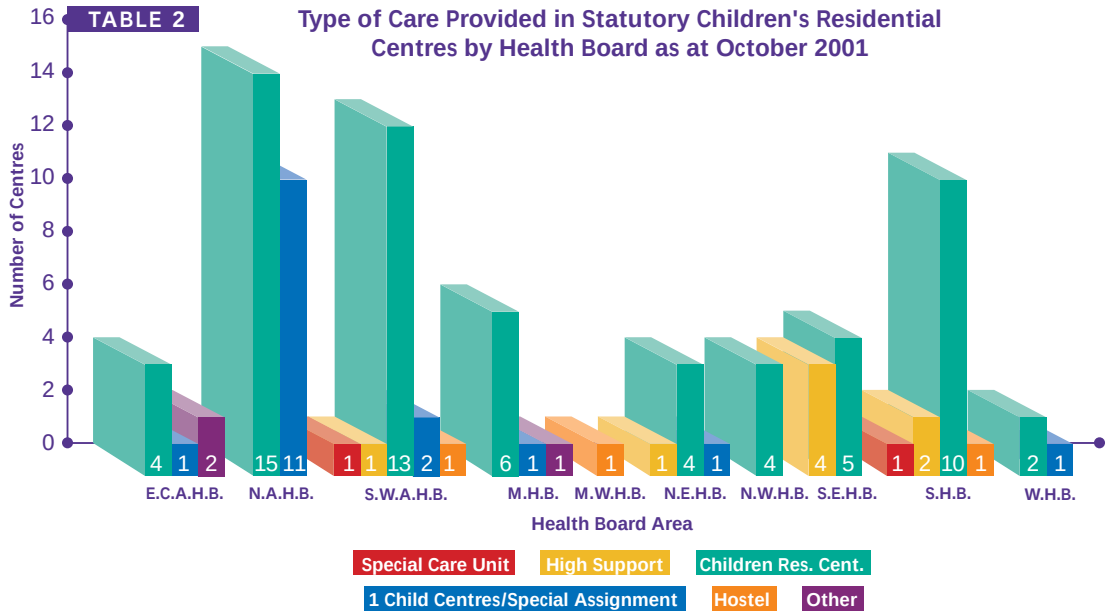
According to SSI's latest information there are now 155 centres in the statutory and non-statutory areas. This figures represents community-based children's residential centres, high support and special care units, special arrangements for sibling groups and special arrangements for individual children. When the Inspectorate was established, it was estimated there were approximately 100 such centres around the country.

2.2 Number and category of statutory children's residential centres per health board

Reference: Table 2 (following page)

There are 96 centres amongst the ten health boards. The flatness of the range of services is striking. Special care units are provided regionally, however, only half of the boards have high support units. The non-statutory sector generally provides community based services, with the exception of those in the MWHB area. The table above gives a reasonable overview of the different types of children's residential services available.





N.B. Other = After care or mother & baby home with facilities for young people in care under 18. S.H.B. includes 1 assesment centre.

2.3 Special arrangements

The term 'special arrangement', a new expression for the inspectorate, describes provision for a child or children in the care of the health board which is neither foster care or an already established children's residential centre. A special arrangement usually arises from one of the following four reasons: i) in response to a high court order stating that the child is to be kept in a secure placement, and the health board is unable to locate such a placement; ii) as an emergency response to a child in its care for whom no placement could be found; iii) as a planned placement for a child with unique difficulties, following a comprehensive assessment; and iv) a family group of brothers and sisters, in need of care and whose interests are served if they remain together, sometimes within the family home.

The Inspectorate is concerned at the development of many special arrangements of the first two types, developed as emergency responses to a lack of suitable available placements. This indicates a crisis in placement provision and the development of emergency single arrangements is only a short-term solution. The placement crisis will be helped when Ballydowd special care unit is fully operational, when the new special care unit in the MWHB is opened and when the two commissioned high support units are fully operational. However, not all special arrangements concern children awaiting a place in a special care or high support unit.

SSI has been notified of 17 special care arrangements for individual children in six health boards. The length of time that children have been placed in the arrangements varies from two to eight months and is ongoing in ten of the arrangements. The premises used to house these arrangements belong to the health board in five instances and are in rented apartments or houses in four cases. A health board reported that two special arrangements are situated within Bed and Breakfast establishments. In addition to these numbers, health boards also refer children to a private children's residential centre that places children in single houses with a full staff team. In October this organisation had five centres that accommodate one child only.

This type of children's service is a matter of concern. First, it indicates a lack of planning and provision, as the board finds itself without suitable placements for vulnerable young people. Consequently, the time and energy of senior managers and staff is focused on developing individual short-term solutions. As individual cases arise in different geographical areas, expertise developed in one area is rarely applied in another. Second, there are value for money questions regarding some of these arrangements. Third, many of these special arrangements are staffed by agency staff, often untrained in child care and with no long term commitment to the child. In the absence of a suitable placement being available in the short or long term, the special arrangement can become a mere holding

placement where the reasons that led to the child needing the placement are not addressed.

Where the placement is a secure one, the young person is detained without the benefit of the safeguards that are experienced by other children placed in special care arrangements. These include a pre-opening inspection, support from a peer group, a dedicated statement of purpose and function and a greater number of visitors to the centre generated by more resident children. When the placement is put in place rapidly, there are rarely written policies and procedures to guide staff on care practices. This is of particular concern where the board is unable to staff the placement with trained and experienced staff and uses agency staff on a full time basis.

SSI is concerned at the isolation such children experience. Many placed in special care arrangements do not attend school outside their placements but receive tuition in the centre; they spend all their time in the company of adults. When shift working is taken into account, 12 different staff could care for the young person within a week. In the care of agency staff this number could be much greater. The Inspectorate appreciates that there may be occasions where, for a short time-limited period, a young person may be so distressed that they are not able to be in the company of other young people; however, this should not develop into a long term arrangement. Young people deprived of the company of their peers over a long time are denied an essential developmental opportunity and are not being prepared to re-integrate with society.

Health boards, developing special arrangements for children in care, have done so as a response to a child or young person who could not be catered for within their community based services. Boards should consider supporting community based services further by assessment, care planning and specialist support. Additionally, by providing a range of children's residential services; community based, high support and shared care with other interventions as necessary, boards should be able to maintain children within the board's managed and planned services. Where unforeseen emergencies requiring immediate residential placements occur, the board should have a policy stating the standards and procedures to be used for the establishment of any special arrangement. The development of special arrangements risks diverting health board attention from reviewing limitations within centres where placements have broken down. The boards are advised to use their own monitoring arrangements to ensure that statutory requirements are met and best practice achieved in special arrangements.

3. Inspection of Children's Residential Centres

3. Inspection of Children's Residential Centres

This chapter outlines the inspection work of SSI and the Registration and Inspection (R&I) units of the health boards.

3.1 Social Services Inspectorate, health board Registration and Inspection (R&I) units

Sections 61-63 of the Child Care Act 1991, provide for the registration and inspection by health boards of children's residential centres run in the non-statutory sector. Section 69 of the same Act authorised the SSI to inspect children's residential centres run by health boards.

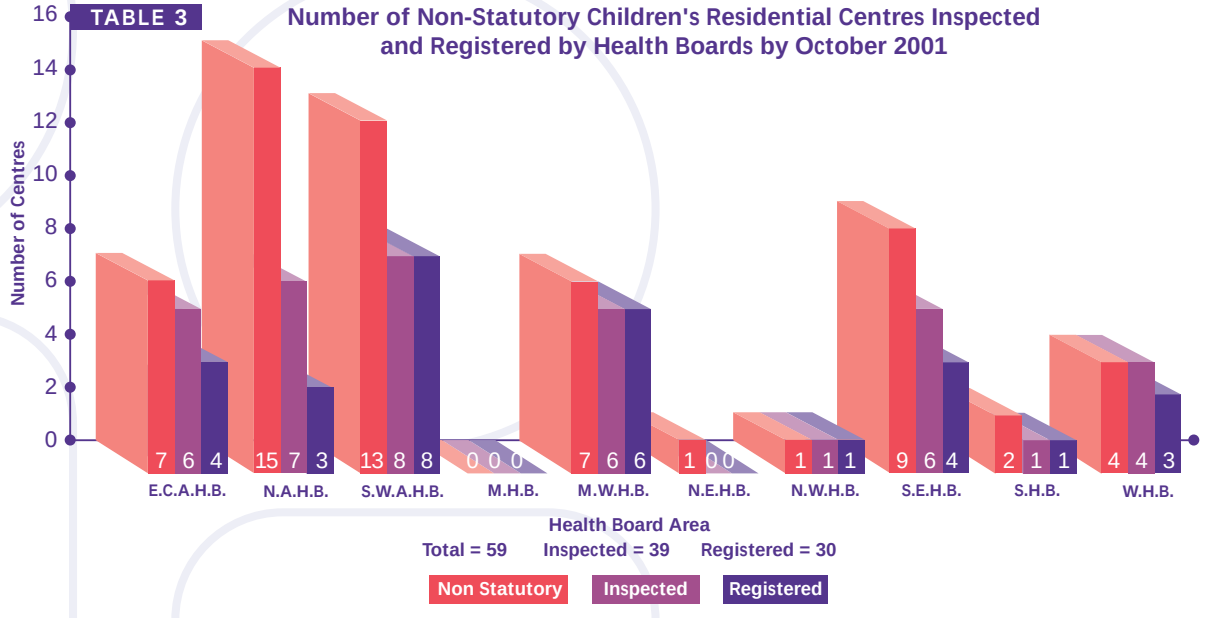
Since September 2001 all centres are inspected against the National Standards for the Inspection of Children's Residential Centres. Health boards send their inspection reports to the Chief Inspector of SSI to ensure equitable standards of inspections are maintained. The Chief Inspector is in discussion with the Chief Executive Officer's National Advisory Group on Residential Inspection regarding standards, reports and recommendations. SSI also meet with health board inspectors regularly to discuss issues of mutual interest.

Health boards have opened the majority of new centres or special arrangements in the past year. In part, this reflects the continuing withdrawal of religious orders and voluntary committees from the provision of residential child care. However, this reduction of providers in the non-statutory sector may be replaced by private companies, as SSI and R&I Units are aware that some companies that provide residential care in the UK, are interested in opening services here. The R&I Units are developing a pre-registration pack that will assist any organisation interested in setting up children's residential services in this country in the non-statutory sector understand fully the legal, regulatory and standards requirements.

With the exception of the MHB, all boards have non-statutory services providing children's residential centres within their area. The numbers vary considerably as can be seen in table 1.

TABLE 3

Number of Non-Statutory Children's Residential Centres Inspected and Registered by Health Boards by October 2001



Three boards have established permanent R&I Units to register and inspect centres, and in some instances, to monitor standards within their own centres. These boards are the Northern Area Health Board (NAHB) offering a regional service for all three boards within the ERHA area, the Mid-Western Health Board (MWHB) and the Western Health Board (WHB). Other boards have put in place temporary inspection teams, drawn from their child care personnel, to register and inspect non-statutory centres. Health boards with temporary teams need to be alert to the requirements of pre-registration for non-statutory services establishing in their board area.

3.2 Number of health board R&I units inspections and registrations in total by health board

Reference: Table 3

Health boards have informed SSI that, out of a total of 59 non-statutory centres in their areas, 39 have been inspected and of that number 30 have been either fully or conditionally registered.

The R&I Units registers a centre if it complies with all statutory standards and provides a good level of care. In general, even with registration, the inspector may have advice for the centre regarding best practice. Where an inspector is of the view that a centre has to comply with recommendations before being registered, it is registered with conditions. The inspector has to be satisfied that these conditions have been met before it is fully registered.

3.3 Findings of R&I Units

All inspection reports leading to registration are available on request from the local health board. It has not been possible to do complete analysis findings of all R&I Unit inspections as reports are written in different styles. However, it is possible to make some broad generalisations. From September 2001 all inspections will be against the same national standards and this should facilitate easier access to findings across all centres, statutory and non-statutory.

The NAHB figures in relation to the first 19 centres inspected since it was established show that 41% of staff held recognised qualifications (86 out of 209 staff). This figure has been somewhat distorted by the fact that three centres, opened in the private sector, had no qualified staff at the time of inspection.

The figures from the same R&I unit's inspection of 19 centres, where 110 children lived, showed that there were care plans in place for 81 children, and statutory reviews were held for 89 children. Ninety-two of this group of 110 children and young people had an allocated social worker at the time of inspection.

3.4 Number and category of children's residential services inspected by SSI

Reference: Table 4 (following page)

SSI has inspected a total of 35 centres since January 2000 and the findings of this report relate to the 23 centres inspected between July 2000 and July 2001.

Reference: Table 5 (following page)

3.5 Follow up to recommendations of SSI inspections

SSI operates independently from the DoHC and produces its own inspection reports. Agreement was reached when SSI was established that the DoHC would follow up, in consultation with SSI, the actions taken by health boards in response to inspection recommendations. SSI reserves the right to re-inspect any centre and has done so in two instances. In line with the agreed inspection process, boards were to write to the DHC and indicate their plan of action to inspection recommendations. There has been a low response to the reports published since July 2000. This response rate is not necessarily an indicator of the rate of implementation of inspection recommendations but where a board does not respond the picture remains unclear.

The SSI Steering group has proposed a change in the inspection process in the area of follow up to clarify implementation rates. The DHC and SSI will now meet with the board three months following the publication of the inspection report to see if the board's actions satisfy the recommendations made in the report. This should also alert the DoHC and SSI to difficulties boards may experience in implementing certain recommendations. Where help or guidance would be of value the SSI and the DoHC will try to be of assistance. Follow up of this nature will also advise the DoHC and SSI of issues of national importance.

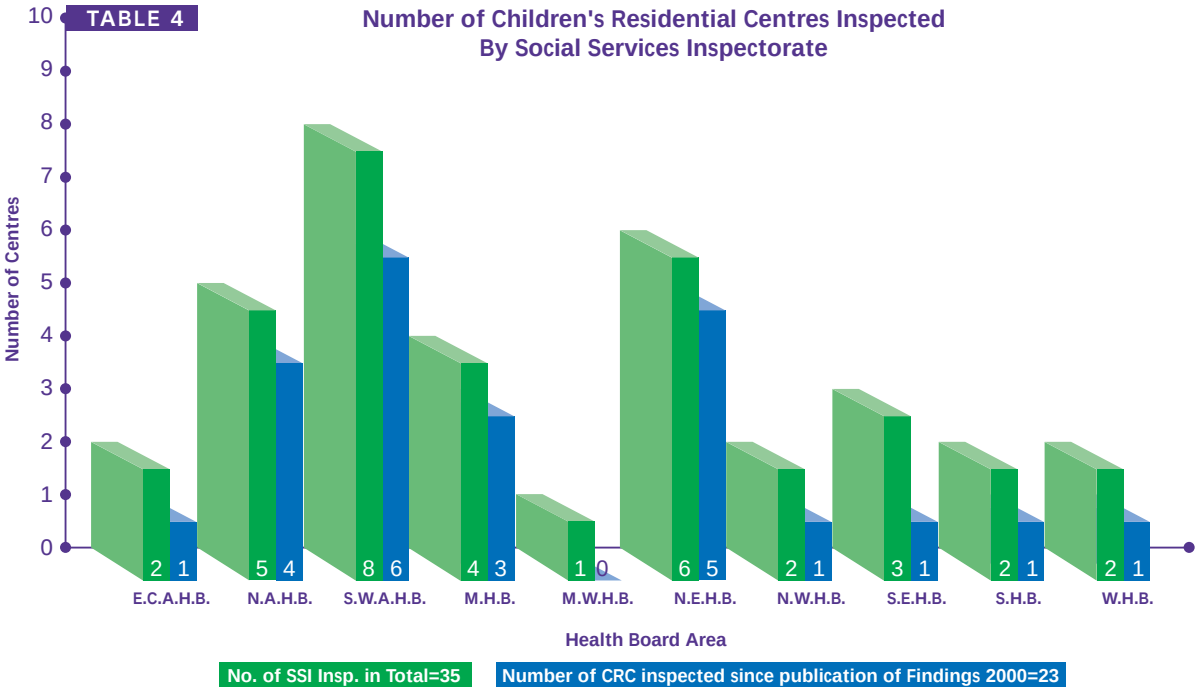


TABLE 4
Number of Children's Residential Centres Inspected
By Social Services Inspectorate
Number of Centres
Health Board Area
E.C.A.H.B.
N.A.H.B.
S.W.A.H.B.
M.H.B.
M.W.H.B.
N.E.H.B.
N.W.H.B.
S.E.H.B.
S.H.B.
W.H.B.
No. of SSI Insp. in Total=35
Number of CRC inspected since publication of Findings 2000=23

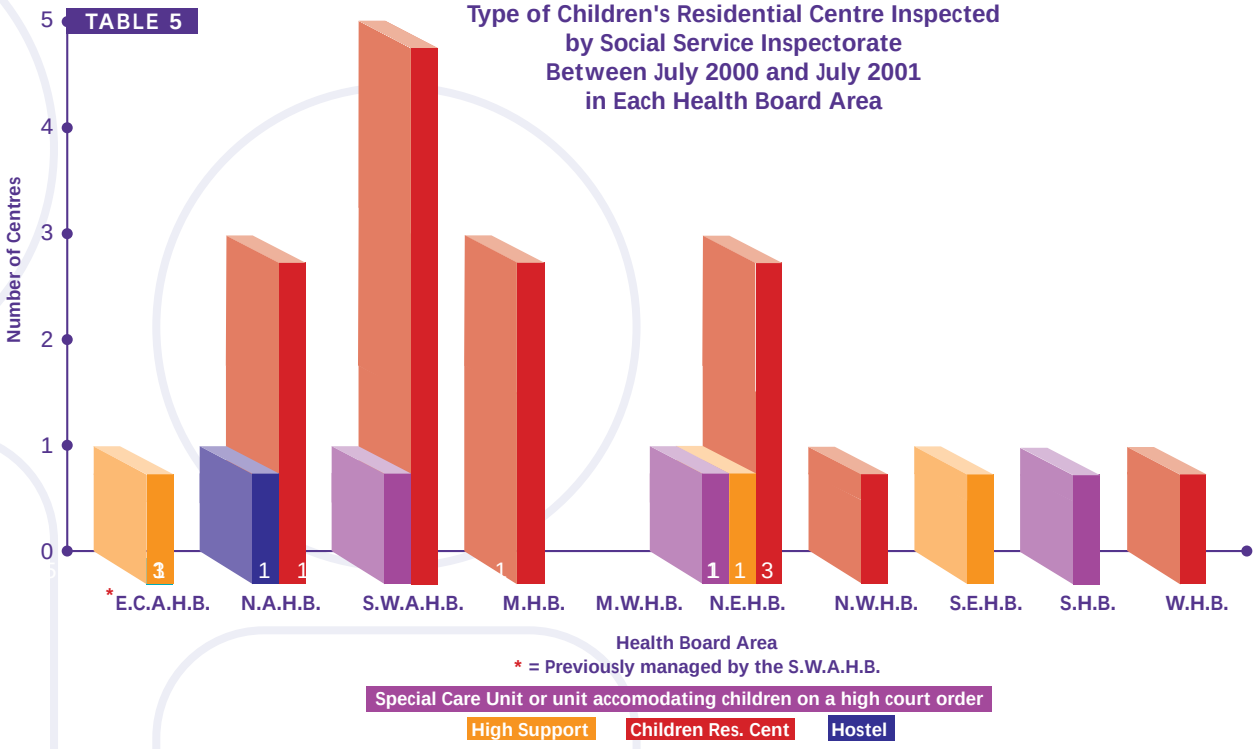


TABLE 5
Type of Children's Residential Centre Inspected
by Social Service Inspectorate
Between July 2000 and July 2001
in Each Health Board Area
Number of Centres
Health Board Area
* = Previously managed by the S.W.A.H.B.
Special Care Unit or unit accomodating children on a high court order
High Support
Children Res. Cent
Hostel

4. Inspection Findings of the Service

4. Inspection Findings of the Service

The findings outlined in this chapter are based on 23 inspections that took place between July 2000 and July 2001 in 21 centres. Two inspections were re-inspections and this is reflected in some of the tables.

4.1 The children and young people

The data relates to the centres that were inspected and should not be generalised to all children in care. Centres were selected randomly for inspection, the only criteria being to visit all health boards and to inspect special care units annually. The MWHB does not feature in this year's inspections since all but one of its children's residential centres are run by the non-statutory sector. The single centre run by the board was inspected in 2000.

Ninety five children live in the 21 centres, averaging between four and five children per centre. The range was from one child to eight children.

Reference: Table 6

Table 6 also shows that of the 95 children, 35 were girls. Given that all the centres, except one solely for girls, catered for both boys and girls, this is a significant difference.

Reference: Table 7

Approximately half of the children are placed in care by voluntary agreement with their parents. The authority of the health boards to hold other children in care divides between Care Orders, Special Care Orders and Wardship proceedings.

Reference: Table 8

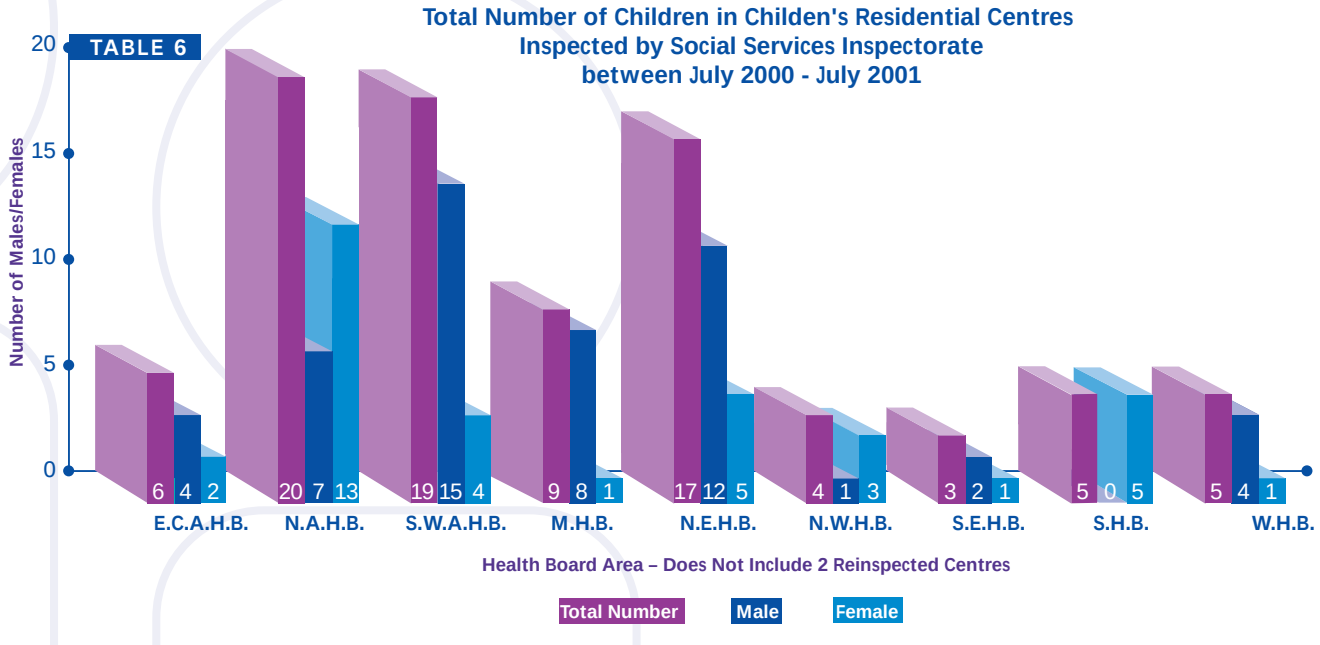


TABLE 7

Type of Care Order on Children Living in Children's Residential Centres Inspected by Social Services Inspectorate between July 2000 - July 2001

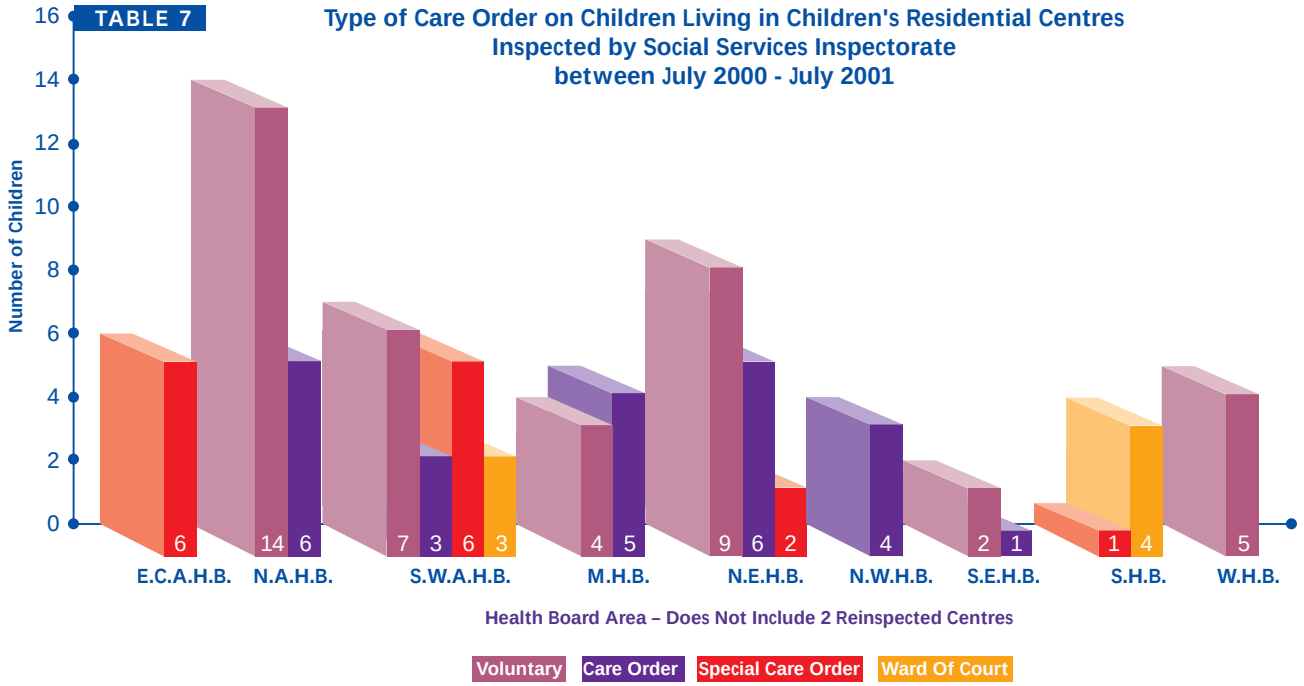
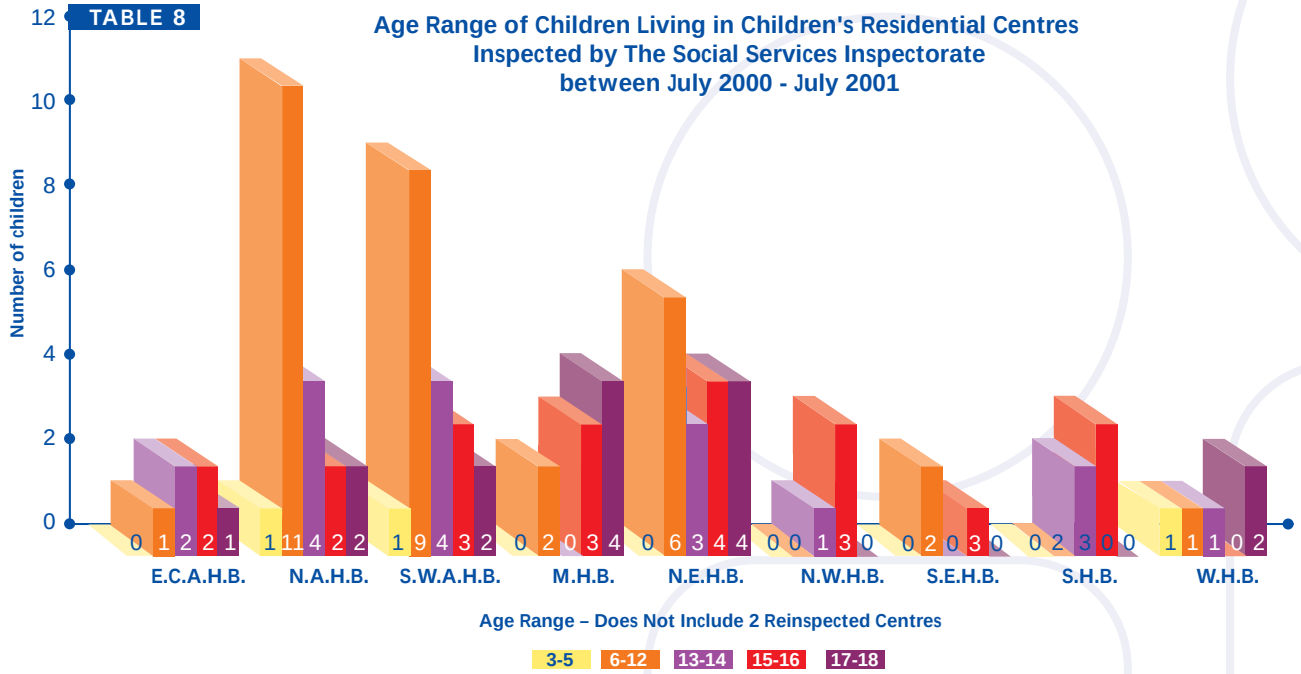


TABLE 8

Age Range of Children Living in Children's Residential Centres Inspected by The Social Services Inspectorate between July 2000 - July 2001



The majority of young people living in inspected centres are between 13 and 18 years (60%). A significant 36% are between six and 12 years and three per cent are between three and five years old. The first 12 inspections, reported in October 2000, found the majority of the young people were adolescents. This round of inspections, in which a further 21 centre were visited, showed a higher percentage of younger children in residential care.

The inspectorate was most concerned to find three children between the ages of three and five years (who were not part of a sibling group) in residential care. In two instances the children were waiting for foster placement, in the third the child needed a different placement. A small number of children between six and 12 years are accounted for by being cared for as part of a sibling group. Staff members and social workers report that other children under 12 years are there as a result of a breakdown of foster care or due to a decision that they need additional help before being considered for foster care.

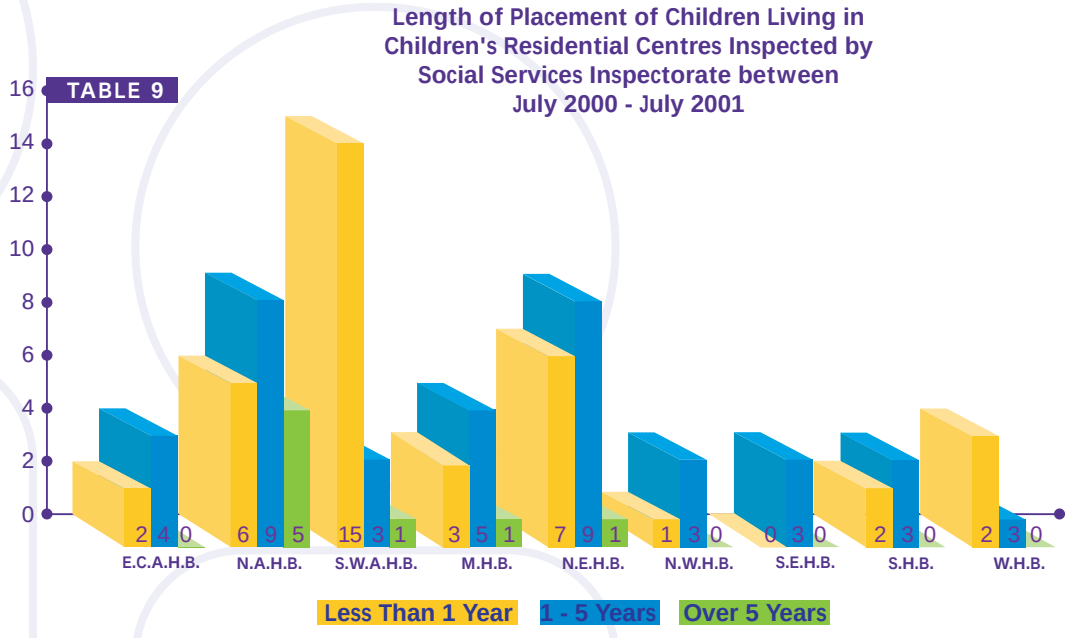
Reference: Table 9

Forty five per cent of children are in the residential centre for less than one year and the same number, 45%, are in the centre for between one and five years. The remaining children and young people are there for more than five years. This indicates a clear divide between new admissions and a stable group of medium to long stay children. These figures indicate a need for separate centres for admission, short term and respite centres and medium term placements. SSI has not looked in detail at the circumstances of those children in their first year in the centre, but research indicates that children who come into care and do not go home within six months are unlikely to go home for many years. These figure do not tell us how many of those recent admissions came directly from their family home and how many came from other placements. Social workers and residential care managers should review recent admissions and assess the attempts made in the early months to reunite them with their families or indeed the placement from which they were admitted.

4.2 Staffing

4.2.1 Recruitment and induction

Staff recruitment and retention continues to present serious difficulties for health boards. Boards have used new initiatives to try to deal with these difficulties including campaigns to recruit qualified staff, recruitment of staff from abroad, and contracting recruitment consultants to



obtain staff. Despite this, boards report continuing difficulties. The training and qualifying bodies state that young graduates show a preference for working in community based child care posts or in other areas of social care.

The Inspectorate urges boards to address the retention of existing staff and to encourage graduates to work in the area. This should include offering permanent posts and conditions of service that support professional development such as induction, supervision, in-service training and multi-disciplinary working. Some boards have put these supports in place, others are planning them and the Inspectorate expects to see their impact throughout the next round of inspections.

In the centres inspected it was noted that 52% of full time staff were employed on permanent contracts and 48% were on temporary contracts. Furthermore, staff recruitment difficulties have led to posts being filled by part time relief workers.

Reference: Table 10

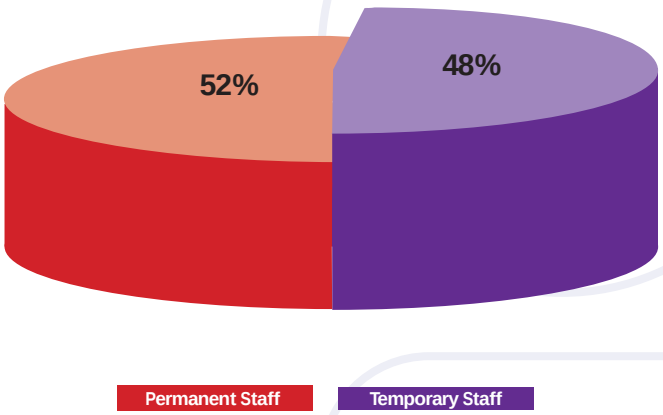
Of the total number of staff employed in centres, 31% were employed on a relief basis. Ten centres employed between one and three relief staff; two centres employed five relief staff; five centres employed between seven and eight relief staff and one centre employed 11 relief staff. Finally, one centre had 29 relief staff rostered to work in a given week.

In the centres that employ care staff as house-parents or assistant house-parents, 76% were employed at assistant houseparent level. This shows that it would not always be possible to have at least one member of staff on each shift at house parent or child care leader level. In most centres no distinction was made between the roles and responsibilities of house parents and those of assistant house parents.

Continuity and stability of care requires the creation of a stable work environment. In those centres with high levels of both temporary and relief staff the task of managing, supervising and monitoring practice is all the more burdensome for centre and line managers. Stability requires a permanent and qualified staff group whose roles and responsibilities are clearly outlined. The pay agreement for this sector introduced in 2001, with corresponding restructuring arrangements, qualification requirements and promotional structures, should assist

Percentage of Staff Employed in Children's Residential Centres Inspected by Social Services Inspectorate between July 2000 & July 2001 on Temporary and Permanent Contracts

TABLE 10



health boards in reducing the impermanence that has characterised residential child care in recent years.

The recruitment of residential care staff to permanent posts is generally the responsibility of the personnel section of the relevant health boards. All staff, including temporary staff are required to be appropriately vetted before commencing duty, through the taking up of past employer references, including the most recent reference, and requesting criminal records checks from An Garda Siochàna, or other police authorities. SSI inspection of a random selection of personnel records found that appropriate vetting of staff had taken place in respect of 15 out of 21 centres. In the remaining six centres, there were instances in four of the centres of staff members starting work between two weeks and two months before Garda clearance was received. In one case a staff member was employed 11 months prior to clearance. There were also instances in four centres where references were not available for some staff members, or where only one reference was obtained; this failed to comply with the board's own protocols, which require two references for each staff member.

The SSI takes a serious view of such situations that suggests that sufficient safeguards have not been rigorously adhered to.

Induction

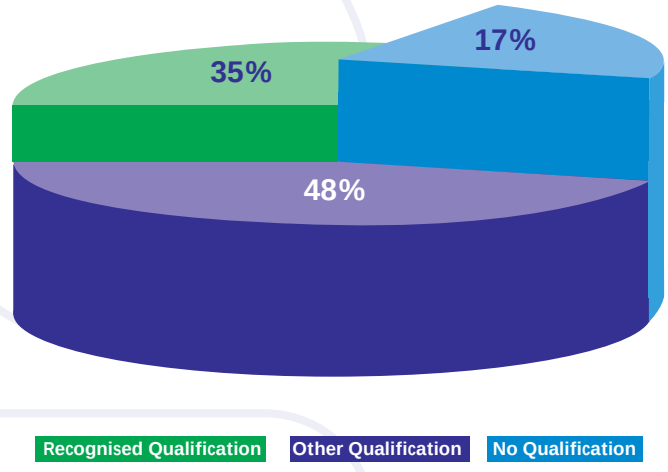
Induction training for new staff requires continued improvement. Only three centres had access to a formal induction programme organised by the board. Instead, new staff members were required to read the policy and procedures documents and could 'shadow' staff for a limited number of shifts, although in practice this was not always possible due to staff shortages. Given the generally poor performance in relation to the provision of staff supervision (see 4.2.4) it is difficult to see how centre managers ensure that new staff have sufficiently familiarised themselves with the policies and procedures that inform practice in the centres.

4.2.2 Staff Experience

The length of staff service in the different units varied considerably both within and between centres. Four centres had an experienced staff group, most of who had been employed in the centres for a significant number of years. A common pattern was a staff team divided into two groups, one with several years' experience, the other with much less (ranging from a few weeks to two years).

Percentage of Staff Holding Qualifications in Centres Inspected by Social Services Inspectorate between July 2000 and July 2001

TABLE 11



While the less experienced staff will learn from their more experienced colleagues, of particular concern to the Inspectorate were those centres that had a large number of relatively new staff. In one centre two-thirds of the staff team had less than two years experience in the centre. Another unit had eight out of 14 staff in post for less than a year. Finally, the longest serving member of staff in one unit had two years' service, two staff had 15 months service, and the remaining six staff had less than four months experience.

4.2.3 Qualification and Training

Reference: Table 11

Thirty five per cent of all staff had a recognised qualification, 17% had no qualifications and the remaining 48% of staff had other qualifications of varying relevance to residential care work. Qualifications included degrees in social science, psychology and education; diplomas and certificates in counselling, addiction studies, child protection and welfare, youth and community studies, supervisory management, and nursing qualifications in general, mental handicap and psychiatric nursing.

The level of qualification was less with relief staff. Eighteen per cent of all relief staff held a recognised qualification in child care, 63% held related qualifications, and the remaining 19% had no qualifications.

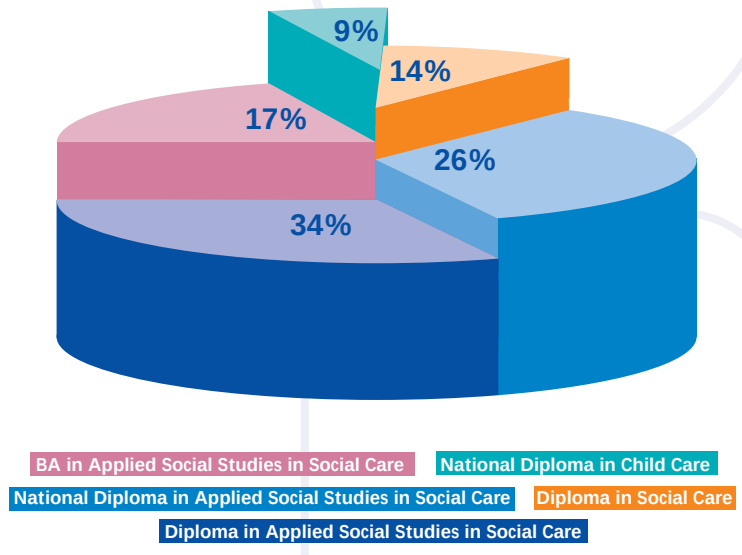
Reference: Table 12

Although many staff without recognised qualification make a major contribution to running centres, it is vital to increase the proportion with recognised qualifications. The challenges involved require members of the team to share a common understanding of their task and have the knowledge and skill to work to the highest standards. This in turn means that those charged with the education of child care workers should help the staff with related qualifications and relevant experience to gain full qualification, both by retrospective evaluation and certification of other qualifications and experience and by qualifying courses.

Additionally, as boards are recruiting care workers from abroad, the Inspectorate recommends that a national body is charged with recognising suitable foreign qualifications and assisting boards in their recruitment drives.

Type of Recognised Qualifications of Staff in Centres Inspected by Social Services Inspectorate between July 2000 and July 2001

TABLE 12



A number of health boards are presently supporting staff to become professionally qualified with fees assistance, time off to attend lectures and replacement staff costs for relief staff. Additionally, some boards are negotiating with course providers to provide qualifying training for their staff as a group. An initiative has been set up between the MWHB and the Limerick Institute of Technology to run a certificate in Applied Social Studies. It has 18 students, all of whom are working in the sector. It is hoped this training will develop in the future.

In-service training opportunities differ from board to board. In some cases staff completed courses on play therapy; helping young people that have been bereaved; meeting the developmental needs of pre-adolescents; sensory integration; solution focussed therapy; drug awareness; depression; group work skills; attachment etc. One board organised specific in-service training for residential workers involving a number of modules. Training officers for the child care area, in place in some boards, assist in developing this area.

4.2.4 Supervision

Supervision should be part of the support given to residential care staff to help them maintain high professional standards. While widely acknowledged it is not generally reflected in practice.

Regular staff supervision was provided in just four of the 23 centres. It is formal, recorded and supported by an agenda. In one special care unit, staff were additionally provided with team supervision. Staff members found this a positive experience, providing an opportunity to ask questions, raise concerns, and to gain the support of colleagues.

In ten of the centres individual supervision was provided on a periodic basis. In one of these centres, supervision was provided only for unqualified staff and in two centres supervision had not taken place for at least six months prior to inspection. Two other centres had recently introduced supervision and a number of the staff had yet to have supervision. Supervision was not provided in seven of the centres. While all managers acknowledged the value of supervision, the reasons offered for not providing it related to workloads, being required to do shift work at times of staff shortages, administrative duties, and a lack of confidence or training to provide supervision. SSI welcomes the steps being put in place by some boards to offer training to first time managers.

Support and supervision arrangements for centre managers generally involved meeting with their line manager on a six weekly basis. For some managers these meetings take place on a formal basis and records are kept. In two cases centre managers also had access to external supervision and consultation.

Supervision in relation to day-to-day practice and professional development is the main means by which staff can integrate learning and experience, and managers can monitor staff performance and progress. Health boards should remove the main obstacles to its provision.

In 12 of the centres staff had access to an external consultant to assist them in reviewing work practices in order to offer more appropriate and consistent care. Such sessions help staff identify different ways of understanding and responding to young people's behaviour. They can also play a valuable role in sustaining placements, in which caring for some young people can be particularly challenging.

4.2.5 Duty rotas

Staff rotas are designed to provide adequate cover at all times and ensure that sufficient numbers of staff are present when young people are in the centre. The rota additionally accommodates communication between shifts and weekly staff meetings. In general, the SSI found rotas sufficiently flexible to achieve these ends.

The most common shift pattern is that of a 24/25-hour shift with a smaller number of centres working a combination of six, eight and 12-hour shifts. The minimum amount of staff on duty is two, as was the case in four of the centres. However most of the centres provide for at least a third member of staff for additional cover at particular times during the day, such as evenings. Twenty-four hour shifts can provide continuity for young people in relation to daily care. They are also attractive to staff in allowing longer

periods of continuous time off duty. However where staff work long shifts, caution is needed to make sure they remain alert. In principle 24-hour shifts can provide staff with time off to rest and recuperate. They can be less effective in practice, if staff members find themselves covering extra shifts due to staff leave, or to facilitate attendance at college. This was a concern in a small number of centres. Night cover is managed in the following ways; ten centres had two staff providing sleep-over duty; four centres had live night duty only; and in seven centres there was a combination of both live night duty and sleep-over duty.

4.3 Premises

The majority of children's residential centres were located in domestic homes near community facilities and were suitable. Other centres, such as special care units, were more institutional, but their structure and organisation were determined by their purpose and function.

Premises were found to be unsatisfactory for the following reasons. In five instances they had been inappropriately reassigned from another use, in four instances they were in extremely poor state of repair and two of these centres had to relocate immediately due to fire safety concerns, and tenancy was insecure or unreasonable in three.

Seven centres were well maintained, some to an extremely high standard. Many had difficulty in securing repairs and maintenance and several were in need of decoration. In some the furnishings were poor quality, and inspectors made specific recommendations about kitchens, dining rooms and children's bedrooms being brought up to standard.

Health board managers should arrange for the centre manager to access maintenance arrangements locally and quickly. Centres should have an annual budget for decoration.

4.4 Purpose and function

All centres, but one, had a statement of purpose and function. Six statements were in draft form and half of them were being drafted during inspection. One centre had a draft statement that health board managers regarded as an accurate reflection of health board policy. It was unclear why it was still a draft statement.

Inspectors considered six statements to be of a high standard in that they were well understood by staff and were put into practice. These statements described what the centre sets out, to do guided the service that the board and centre offered in the centre and stated clearly how it was to be delivered. They stated whether the centre was for emergency, short or medium term care, and which age group, gender and geographical area of children would be considered for admission.

Where there were realistic statements, accompanied by clear policies and procedures that were reflected in practice, the standard of care provided in the centre tended to be of a high standard. This bears out consistent research findings, that where the task is clearly defined and staff members know what is expected of them, they will deliver a good standard of care.

The CEO's National Advisory Group on Residential Care reports that work has been undertaken in all boards to develop statements of purpose and function. Inspectors are aware that the standard in this area has improved considerably from early inspections and commends the work undertaken.

However, not all statements were of a high quality. Some statements simply failed to describe the service being offered, omitting, for instance to identify the target population, the catchment area or whether the unit was single sex or mixed. Other statements asked centres to do too much, while yet others failed to mention functions which were being carried out. A common occurrence is where centres set up to offer short term care end up keeping young people for two or three years because of the difficulty of finding placements for them.

4.5 Admissions policy

The majority of centres have an agreed policy for admission of children. In a minority of centres this was not the case. Where admissions policies were adhered to, the

overall standard of care in the centre was strengthened. Many centres and boards now have admissions panels. The majority of centres had occasion to admit young people on an emergency basis yet only one had a policy and procedure to deal with this eventuality.

Inspectors were concerned to learn that in one board young people were being transferred around various centres as a way of managing difficult situations and accommodating other young people. In one unit, half the residents had been transferred from other units while in another, a young boy had been admitted for a couple of days 'respite'. He was still there four months later. In these situations the children had not been consulted and were unsure what was going to happen to them. The process of their admission was adversely affecting their relationships with the staff group caring for them and inhibiting their ability to settle. This practice is highly undesirable, and appears to have more to do with managing the system than meeting the needs of the children.

Admissions panels have an important function to play in children's residential centres but this is frustrated where many admissions are on an emergency basis. Last year's report noted that the boards often knew the children admitted to centres in emergencies, which in principle should allow for greater planning. This situation has not improved. Emergency admissions by-pass the measures health boards put in place to minimise the inappropriate use of residential care. The boards need to address this issue as a matter of urgency. Placing children inappropriately (in the only available placement) is damaging for the young person, undermines the centre, and adversely affects the care offered to other children. The boards must try to reduce the number of unplanned admissions and have procedures in place to deal with emergencies. The gate-keeping function of admissions panels should be extended to ensure they consider unplanned admissions as soon as possible after they occur. This would act as a safeguard against the inappropriate use of transfer as a means of control.

Good statements in children's centres need to be backed up by clear admissions criteria and procedures. Inspectors found that those centres offering good quality care most often had clear admissions policies that were put into practice.

4.6 Care plans

Inspectors found 51 care plans for 91 children (56%) during the 23 inspections. This is less than in the first 12 inspections (80%). Some of the care plans were poor and they fell below the standard required by the Child Care Regulations, 1995.

Despite this generally poor picture, some boards are taking their responsibilities seriously and developing their practice. Inspectors saw examples of newly developed standard care plan forms which offered guidance to social workers on both the process (involving assessment of the child's needs and consultation with children, families and professionals) and the product (entailing goal-setting and identifying tasks for completion). Inspectors saw evidence of good care planning. In one centre, care plans for the three resident children were excellent. Two other centres in the same community care area showed evidence of good quality care planning. A key factor here was the leadership and professional commitment of the principal social worker to ensuring there were plans for all the children in care. A shortage of social workers was not a factor in the availability of care plans in this round of inspections, as all children in inspected centres, with the exception of two, had an allocated social worker. In one special care unit where only half the young people had care plans a social work team leader spoke about the difficulty of identifying post special care placements.

Where care plans failed to meet the required standard there were a number of factors at work. In some cases social workers did not follow the appropriate process: there was no proper assessment of the young person's needs or little or no consultation with the child or family. Other plans failed to identify the supports to be offered to families, to deal with access arrangements and to specify how the plan was to be implemented.

Where care plans are not in place there is a lack of lack of formal consultation with the child or young person. The right of young people to be involved in decisions about their care is enshrined in both the UN Convention on the Rights of the Child and the Child Care Act, 1991. In particular, proper care plans for those in special care units are of vital importance. Their freedom to make choices has been severely curtailed. It is crucial to avail of whatever opportunities exist to facilitate them to express their opinions and wishes.

Many residential staff teams develop comprehensive placement plans to guide their work with the young people. These are often based on thorough need assessments and consultation, and many are of a high standard. This work is important but its value is limited if the placement plan is not part of an overall care plan.

Some care plans were produced years after the young people were first admitted to care. Very few were produced within the time scale required by the Regulations.

SSI is aware of new developments in several boards to ensure that every child in care has a care plan of good standard. These initiatives are commended, and it is recognised that it is difficult for this standard to be fully met in the short term. It is not acceptable that children in care should wait for care planning, these should be developed in accordance with the Regulations as a priority.

4.7 Review of care plan

Compliance with the Regulations was more apparent in relation to reviews, at least in terms of the timing and frequency of review meetings. There was, however, evidence of some confusion as to the purpose of reviews.

Often review meetings took place in the absence of, or prior to the formulation of, a care plan. Many considered the progress of the young person in the placement rather than reviewing the degree of implementation or impact of the earlier agreed plan. Even where care plans were in place there was a distinct tendency for review meetings to review the placement rather than the care plan.

Practice in relation to the involvement of the young people and families varied a great deal. In two special care units and some other centres, it was very good. The young people were invited to attend all of the review. Parents were helped with transport arrangements. The meetings were recorded and copies sent to all participants. In other centres, practice was variable and sometimes inconsistent. In one centre the parents of one child were invited to reviews but the parents of another were not. The board lacked a clear policy in relation to the matter. In another centre, family members were informed of decisions taken as they made their way to the review. In this case, the appearance of consultation belied the reality.

Young people were inconsistently invited to their reviews. There may be good reasons not to involve some young people, especially very young children, but inspectors believe that adolescents should always be given the opportunity to participate. Similarly, there seems little value in inviting young people in for the end of their reviews, as happens in some centres, to hear what has been decided rather than to contribute to the process.

In one centre, practice was exemplary. There was a care plan for each child and it had been reviewed. The principal social worker had decided that, for the review to have real significance, the care plan would be re-written at every review. Therefore, the process of consultation, assessment, etc. was repeated. In this case the children were very young and their attendance at the review was not deemed appropriate. However, a meeting had been arranged for the social worker, keyworkers and parents to discuss the outcome of the review with the children. This is practice of a high standard that other boards may wish to emulate.

One health board had reviews chaired by a person not directly involved in the management of the case. This is an interesting and worthwhile development. The responsibility of the independent chairperson is to ensure that the review achieves its purpose which is to review the care plan and ensure that all interested parties are heard and their views given due weight. Participants, especially children, families and non-health board professionals, are likely to have greater confidence in a chairperson whose independence is not compromised by having line management responsibility for the case.

4.8 Family involvement

Practice in relation to family involvement in planning and reviews has been noted above. This section deals with the involvement of families in the every day life of the centres. There were examples of excellent practice and, for the most part, there was good communication and co-operation between centre staff and the families of young people in care.

In one centre, practice was exemplary. Centre staff and parents worked together for the children. Parents saw the centre as a place where they could get advice and support for themselves. The project was seen as a community resource and the parents and children were not stigmatised by using it. In another centre there were three children from the same family. The parents and siblings lived nearby. They were welcomed to the centre, participated in meals and celebrations, helped the children with their homework and took them to appointments with centre staff. The family members all spoke positively of the staff and of the care they offered the children.

While these two examples represented best practice in this area there were plenty of other good examples. In general, parents were welcomed to centres, communication with centre staff was good, and staff and social workers went to lengths to ensure that families had regular contact with their children in care.

In some centres where access was arranged by social workers outside the centre, there was minimal direct contact between centre staff and parents and other family members. In rural areas, this was partly explained by the distances involved. However, minimal contact was noted where distance was not a factor and there seemed no good reason not to involve families more in the children's lives. Some centres had inadequate facilities for family visits. Boards need to be mindful, when choosing or designing buildings as children's residential centres, of the need for a room where family members can have private access to their children in care.

Parents and other family members need to know that the children are being well looked after. Even parents who are in conflict with health boards over their children being in care can co-operate with residential staff. They respond positively when they see that centre workers are doing their best for their children. However, it is vital that there is good communication and that parents know that any concerns they have will be taken seriously. In one centre, the practice of centre staff informing social workers of significant events and social workers informing parents meant that information was sometimes delayed or not conveyed at all. This can lead parents to believe that information is being deliberately withheld from them, which undermines their confidence in centre staff and leads to unnecessary conflict. Parents should be informed of significant events in their children's lives as expeditiously as possible. In one centre, parents had many concerns about a range of issues such as use of physical restraint and locking children in their rooms. These concerns were not adequately addressed; family members lost confidence in centre staff and a hostile relationship emerged between the centre and many of the parents.

Boards need to consider the roles and responsibilities of social workers and residential care workers in relation to contact with families. Children in care have a right to contact with their families. Appropriate means have to be found to facilitate this. Sometimes social workers will arrange and facilitate access, sometimes centre staff will do it. The ideal situation is one where responsibility is shared with flexibility demonstrated on both sides.

4.9 Young people's records

Inspectors found that all centres had records on young people. In the centres where the standard was met there were clear policies about record keeping for staff, and files with comprehensive front sheets and clear divisions which make recording and access to information easy.

However, inconsistencies were widespread and many young people's records are not well organised. Documents such as care plans, birth certificates, copies of care orders or voluntary consent to care forms and social histories, were missing, and routine information, was often not recorded eg. medical information, records of incidents such as unauthorised absences and restraints, records of family visits, and records of social worker visits.

Most centres keep personal memorabilia, certificates, cards, photographs, school reports, and letters on behalf of the young people.

4.10 Supervision and visiting of young people by social workers

This standard is well met across the centres, with social workers visiting within the Regulations in 19 out of 21 centres. In only two instances did inspectors recommend

that a child should be allocated a social worker. Three centres were commended for the service provided to young people by social workers, and inspectors found evidence of good working relationships between centres and social workers. Given the pressures under which they work, in many cases from teams with significant shortages of staff, it is to the credit of social workers that they give appropriate attention to young people in residential care.

Children and young people generally said they liked their social worker but if they have had several social workers allocated to them in a short period they lose the motivation and interest in getting to know another professional. Individual social workers cannot be held accountable for turnover rates but social work managers are urged to try and allocate children in care to social workers who are on permanent contracts and who seem most likely to stay.

Where standards need to improve it is either because the young person is without an allocated social worker or, as in two instances, because social workers were not visiting at the required frequency, or not seeing the child privately but using family access visits to fulfil the requirement. See section 6.4 for comments relating to care planning.

4.11 Management

Different management structures operated across the centres. In general, inspectors found that management structures that offered regular opportunity for supervision, appraisal and evaluation supported centres in improving the quality of care offered. Senior managers specialising in residential or alternative care provision were found generally to be better able to provide this. Inspectors noted most difficulties where centres were line managed by the local principal social worker. The task of managing residential child care had been added on to the management of all social work services in the area and principal social workers, although willing, rarely had the time and sometimes not the expertise necessary to support the residential sector.

The line management structure for high support and special care units was developed to reflect the purpose and function of these units. Managers reported to a general manager, a child care manager and an assistant chief executive officer. Such units had strongly developed centre management structures, which provided for directors/managers; deputy directors/managers; unit managers and team co-ordinators. Such posts can provide a valuable resource to the boards in terms of planning to meet the changes and complexities that characterise residential care today and in engaging both managers and staff in this change. Eight of the remaining centres had a single centre manager who worked office hours and was based in the centre. Two centres had recognised posts of deputy manager as part of the official staffing complement and three centres had a senior staff member nominated to deputise in the manager's absence.

Inspectors found a wide range of ability and competence in the local and line management of centres, and urge boards to focus on strengthening the management function of centres as a prerequisite for the professional development of the service. One board sends all new unit managers to the Institute for Public Administration to undergo management training and another has developed guidelines for first time managers in residential care.

Providing for the leadership, administration, guidance and development of a unit on a daily basis is a challenging task and requires a management structure that facilitates centre managers in providing the best service they can. The time consuming demands on centre managers in relation to supervision, induction, administrative tasks, financial systems, etc., pointed in some instances, to the need for an official deputy post, or administrative support, to enable the manager provide direction to staff regarding placement plans and work with children and their families.

4.12 Role of health boards in monitoring regulations and standards

Article 17 (1) of the Child Care Regulations 1995 states "A health board, for the purpose of satisfying itself that the requirements of articles 5 to 16 of these regulations are being complied with in respect of a relevant residential centre shall ensure that –

(a) adequate arrangements are in place to enable an authorised person to enter and inspect the centre at all reasonable times, and

(b) the centre is visited from time to time by an authorised person."

A new standard on monitoring was developed for the National Standards in Children's Residential Centres to assist boards in their monitoring role.

During this round of inspections this regulation had been adhered to in only three centres. In a further three centres inspectors recommended that monitoring occur as a matter of urgency, and in one, which had been re-inspected, the absence of any arrangement in spite of a recommendation made at the last inspection, was deemed to be a "serious omission". However, several inspection reports acknowledged that steps were being taken to recruit suitable persons to carry out a monitoring role and the inspectorate generally is aware that boards are working on implementing this recommendation in full. The R&I inspector is the monitor in two boards and a child care manager has this role in another board area. Inspectors look forward to finding that regular monitoring is occurring during the next round of inspections.

5. Findings From Inspections of Care Standards

5. Findings From Inspections of Care Standards

5.1 Psychological and emotional development

Inspectors found that this standard was met where there were policy, guidelines and support for keyworkers within a stable staff group and where centres had easy access to specialist psychologist and therapeutic services. Reports from inspections show that centres with settled groups of staff and children are able, in the main, to meet the psychological and emotional needs of the children in their care and that approximately half the centres can easily avail of specialist services.

The keyworker system is a feature of centres' provision for the psychological and emotional development of residents. Twenty of the centres had keyworkers. Their role varied considerably. In a few centres, inspectors came across social workers doing direct work with children regarding the reason they came into care and their feelings.
Children gained emotionally and psychologically where they had a keyworker who had good links with all people outside the centre who had an interest in the welfare of the child. Additional features of the role included a keyworker who attended appointments at a psychological facility with the child and worked in partnership with the specialist service; promoted strong relationships between families and the centre; accompanied children on shopping trips and was the key contact with the child's school or training facility. A small number of keyworkers undertake direct work with the child on the reasons they are in care helping them make sense of past experiences.

In the centres where the standard was unmet the main points of concern for inspectors were difficulties between staff and children in forming relationships due to: the short term nature of the placement; high turnover of staff; staff lacking in confidence; staff lacking qualification or training; and staff unclear about the purpose of the centre. Additional problems arose where there were difficulties in communication between the centre and other services and either unacceptable or inconsistent methods of managing children's behaviour.

Regarding access to therapeutic services, inspectors found best practice was represented by one of two responses. In the first case a centre is able to access community based services in response to a child's needs. Young people are assessed and receive treatment from psychiatrists, psychologists, counsellors, and other therapists. The centre staff have a clear understanding of the child's needs and how the specialist intervention meets them.

In the second, specialist therapeutic services form part of the general provision of the centre to the young people. Examples include a significant input from a multi-disciplinary group of professionals, or regular visits by a child psychologist or child therapist or, in one centre, a psychologist who was appointed to work in the centre with the staff and children. Another unit had the services of a speech and language therapist to work directly with young people assessed with needs in this area.

Where centres referred children to specialist clinics, inspectors found eight centres said they had quick access to the services. Four centres experienced serious difficulties in accessing services, while the remaining 11 found access slow with children waiting for long periods to be assessed.

Overall, inspectors noted that where staff were supported in their work and where they had access to a child specialist who could help staff find ways to respond to a child in difficulty, they were better able to form the relationship that helped the child deal with their individual circumstances. This was of particular value in high support or special care units where children were usually having serious difficulties.

At one centre, which has been re-inspected, social workers still had persistent difficulties accessing therapeutic services for children. This is clearly unsatisfactory as children are waiting for an unacceptable length of time for the services they need.

5.2 Health Care

In the majority of centres the health of children and young people was well cared for with good access to community services, and a good rapport established with health professionals to the benefit of individual children. Across the centres young people were found by inspectors to be enjoying good health, nutritious food, and a healthy life style.

The standard was fully met in one centre where there was a complete policy on health care. All the young people had received medical examinations. All qualified staff were first aid trained. There was an appropriate programme of health education and promotion provided by the staff, and none of the young people at the centre smoked.

In two centres staff were directly involved in health care of children with medical conditions by engaging in either physiotherapy sessions or the daily care of children with complex special health needs.

A high standard was found in 15 centres where the following features were found: a policy and procedure on health care which is reflected in the health care practice in the centre; young people medically examined either before or as soon as possible after admission; a good working relationship between the centre and the general practitioner; medication administered in accordance with the Child Care Regulations with a clear recording system in place; and good health records on health matters were maintained by the centre.

In the seven remaining centres the areas for improvement related to a lack of medical histories, medical examinations and reports, and a lack of vaccinations or reasons noted why these had not been administered.

Inspectors noted that in one centre where young women would have preferred to be registered with a female GP there are still difficulties in finding a GP to meet the need. Two other centres were able to meet the expressions of this preference.

Health Promotion

Most centres have programmes of health promotion that involve staff, particularly in their role as keyworker, providing information and advice on health care to young people. Subjects include healthy eating and diet, the impact of smoking, and alcohol and drug abuse on health, solvent abuse, personal and sexual relationships, and sexual health.

Inspectors found that in spite of the fact that all health boards have no smoking policies, some young people smoked outside the centre and some centres had no programmes in place to encourage them to quit. In other centres advice on sexual health was needed. Across the centres there is a need for formal health promotion training to ensure that staff can provide this service to young people appropriately and sensitively from a sound knowledge base.

5.3 Unauthorised absences

Approximately half the centres inspected reported high levels of unauthorised absences concerning a very small number of children. In reviewing the recording of such absences, inspectors found that many of these incidents recorded involuntary short absences in which the staff often know where the young person was, but which had not been authorised.

However, in the remaining small number of cases, inspectors were concerned due to the high risk associated with vulnerable young people going missing for several hours, overnight or several days.

Inspectors noted improvements in notifying and recording procedures in the inspections undertaken this year. Parents are now more likely to be informed if their child has an unauthorised absence from a centre. SSI welcomes the developments of some health boards in strengthening their inter-agency work in relation to unauthorized absences.

Reasons for children absenting themselves were various. They may not have settled in the centre, have experienced abuse and trauma in the past or are not able to engage and trust the adults caring for them. They often express a wish that they were not in care and say that no one can help them. Professionals working with these children need to develop fully comprehensive care plans and include and consult the children in all circumstances. The work involved with these children can be complex and frustrating for all involved, yet they need to be prioritised by staff teams with specialist support as soon as the first absence occurs. Early intervention is always preferable, particularly when one considers the risk to the young people involved and the extreme care measures that are called for where they continue to put themselves at risk.

5.4 Access to information

In theory children have access to information about themselves in daily logs or diaries and their care and case files. In practice centre staff tend to share the daily log rather than the care file with children. Staff were open to sharing information with children and young people but were hesitant about how to do so. In general, social

workers do not allow children and young people access to appropriate sections of their case file.
All staff need training regarding the Freedom of Information Act 1997 and guidance on how to organise information on files so children and young people can access appropriate information.

Inspectors commend the many centres that now provide written information to children outlining how the centre works, their rights and how to make a complaint.

5.5 Safeguarding and child protection

The vast majority of children and young people in residential care centres confirmed to inspectors that they are safe in the centre. In the main, centres had good safeguarding and child protection practices informed by written policies. Inspectors noted that a lack of regular monitoring by the board was a gap in safeguarding children. Approximately half the centres showed evidence that practice was informed by Children First; National Guidelines for the Protection and Welfare of Children, (1999), however, inspectors recommended in an equal number of reports that the boards should incorporate Children First into centre policy and practice.

Inspectors came across a small number of settings where bullying was a feature. Practitioners are aware that poorly managed episodes of bullying in residential care can put children at risk of emotional and physical harm from other children, and in extreme cases can be a forerunner to sexual abuse. Inspectors urge all centres to develop effective ways of managing bullying before it becomes a problem and enhance the safety of the children in their care.

Overall, inspectors note progress has been made in the development of policies to guide practices. Many boards have trained staff in the contents of Children First. More work need to be done to integrate policies, into day-to-day care practices. Staff are aware of the importance of this area in their work and would welcome training in the area.

Maintaining safeguarding practices is a broader task than having child protection guidelines in place, no matter how well developed. Inspectors, managers and practitioners alike are aware from research and enquiry reports that safeguarding is an organisational responsibility that pervades all areas. Centres with good safeguarding practices will, amongst other activities: encourage children's rights; regularly supervise staff; have clear management policies and practices; monitor care practices; develop a culture of openness and transparency; undertake thorough staff recruitment and vetting procedures; implement good recording systems; have an effective complaints system and child centred procedures for dealing with any allegation of child abuse and provide ongoing training initiatives informed by research and inspection findings.

5.6 Complaints procedure

Inspectors noted health boards had made considerable progress in having written policy statements and complaints procedures in place in the past year. Inspectors found that 19 of the 23 inspections had a written policy statement and a complaints procedure in place. Inspectors found that children knew that they could complain, and to whom they could complain but, in general, they, and parents who met with inspectors, had little knowledge of how a complaint would be handled.

Unfortunately, inspectors found that the inadequacies noted last year regarding the type of complaint procedure in place had not improved. Problems were noted in the lack of clarity about roles, timescales and tasks of an investigation into a complaint. The majority of complaints procedures are not integrated with the health board's main complaints procedure, and complaints were not recorded in approximately one third of inspections.

Other observations made in reports refer to a lack of advocacy for children making complaints, a lack of independence in handling complaints, an overall lack of the right to appeal and a lack of confidence by some children. SSI does not investigate complaints but requires that that the boards' procedures and practice are adequate and that all complaints are brought to a conclusion. Throughout the year several requests for guidance on this area were made to SSI as managers and staff sought to improve this safeguard within their children's services. Consequently, SSI developed guidance notes and these are available since last September and can be found on our website. SSI anticipate that this guidance should ensure the quality of complaints procedures improves over the next twelve months.

5.7 Consultation

Evidence from inspections over the past year suggest that centres are more aware of children's rights, and that centres understand the importance of listening to children and young people. Approximately one third of centres are developing statements on children's rights and one board was commended for fully including the views of young people in its statement. SSI recommends that all boards develop, in consultation with children, a statement of rights for children in their care, and ensure that this is made available to them.

All but one report stated that children's views are sought and listened to regarding daily life in the centre and sometimes through house meetings. Inspectors have found that centres with a small number of children are often reluctant to have house meetings and children in general do not like them if they are held to give staff an opportunity to restate the rules. Staff have expressed interest in establishing meaningful children's meetings and could benefit from training.

Children and young people are consulted on important decisions affecting them and in making future plans for their care. The majority of children are involved in their statutory review of care plan meetings, while five centres limit the extent to which children are involved. Inspectors noted keyworkers preparing children for their reviews, and in nine centres children fill in forms to record their wishes. Inspectors advise boards to develop written guidelines on consultation with children for staff members in order to guard against a loss of impetus due to turnover of staff and children.

SSI holds the principle and practice of consultation with children as essential to good child care practice. The inspectorate is impressed by the efforts made by individual staff and centres in their daily work in developing and sustaining this practice. The Inspectorate developed guidance notes on this subject and these are available on our website or directly from the office.

5.8 Preparation for leaving care and after care

There is an absence of written health board policy on leaving care and after care. Inspectors were only able to credit seven centres with having leaving care policies. Although not all care plans are required to include a preparation for leaving care (only those expected to leave care within the following two years) the figures show that of 14 young people between 16 and 18, only two had evidence of leaving care plans. This low figure is compounded by the lack of care plans for nearly half the young people in inspected centres. It is not acceptable that this regulation is not adhered to, since young people leaving care are amongst the most vulnerable members of the population and need support and formalised plans.

Inspectors are aware of many instances of young people being assisted by staff members within the centre in life skills and in informal plans for their life when they leave the centre. Some staff give of their time and energy generously, but the ad hoc nature of many such arrangements means they are not consistently sustained. As with admissions to care, many exits occur as emergencies and are unplanned. Young people who leave their placement in a cycle of rejecting behaviour also need preparation and support through this period.

5.9 Living skills

In the majority of centres inspectors found young people experiencing a range of activities that promote their interests and help them enjoy lifestyles comparable to those of their peers. In contrast, six reports suggest aspects of institutional practices which inhibit young people's opportunities to develop the skills, competencies and learning experiences necessary for adulthood. Young people are supported to become involved in the community and many are members of local clubs. The majority of centres encourage young people to have friends outside the centre. However some young people commented they did not feel they could invite friends to the centre for meals or ordinary leisure activities. No centre prohibited friends but few really facilitated it as house rules prevented friends visiting young people's bedrooms, or staying for meals or overnights. Several young people mentioned that they found the necessity to have a Gardai clearance before they could stay with friends' families inhibited them in making close friends.

Young people are generally involved in the household routines of the centre, such as undertaking chores, helping prepare meals and weekly grocery shopping.

Inspectors noted that in 13 out of the 23 centres inspected staff and children had to use an order form system, or accounts with local retailers to purchase items of personal clothing, shoes and, in one instance, fast food. This practice was highlighted in the October 2000 report as

identifying young people as being in care. Additionally, it is stigmatising, restricts choice, especially in the matter of clothes and acts as a disincentive for young people to participate in shopping for their own clothes or for the centre's household needs. It is not an appropriate practice for any care centre. Inspection reports recommended that this practice cease and SSI is aware that in the past number of months some boards have introduced changes in this area.

5.10 Use of physical restraint

Inspectors found that two thirds of centres use physical restraint appropriately, and three centres do not use physical restraint. Inspectors had some concerns with the remaining minority. All centres visited employed the Therapeutic Crisis Intervention (TCI) model of physical restraint. Nineteen of the centres inspected had written policies in place on the use of physical restraint, an improvement on last year and inspectors additionally found improvements in recording policies and practices. Whereas the majority of centres had trained their staff in the use of TCI, inspectors noted six centres where some staff were untrained and other centres which had delayed in organising refresher courses.

It is important that key people in line management and monitoring, and those directly involved with the child, are aware of escalations of physical restraint. Inspectors found that only six centres notified incidents of physical restraint to line managers, social workers or parents outside the centre, and recommendations have been made for this practice to become general. In those centres where inspectors had concerns staff reported that they had difficulty in dealing with challenging behaviour and although they recognised the rate of restraint was high, they felt they had no other means of managing the young person.

Four centres use single separation that is, isolating the young person in a room for a specified time. Inspectors were told that the purpose of this is to enable the child or young person to calm down and gain control of behaviour. The centres are either high support units or special care units. Inspectors found the use of single separation was appropriate in all but one centre.

5.11 Sanctions

In general, inspectors found that sanctions are fair, age-appropriate and effective. SSI are pleased to note a considerable increase (21 of 23) since last year (seven of 12) in the number of centres that now have a written policy on permitted and prohibited sanctions. Staff are aware of the policy and this is reflected in their work. Recording was appropriately carried out, either in a separate book or in the child's file in all but one centre. A small number of centres inspected were found to have room for improvement. This was usually where a sanction was being repeated or increased without any effect.

SSI considers that in the past year sanctions have been more consistently recorded, internally monitored and changed where evidence suggested the approach was ineffective. Emphasis is placed on reasoning with the child and encouraging positive behaviour. Care staff try to relate sanctions to the behaviour that they are seeking to change.

5.12 Working in partnership

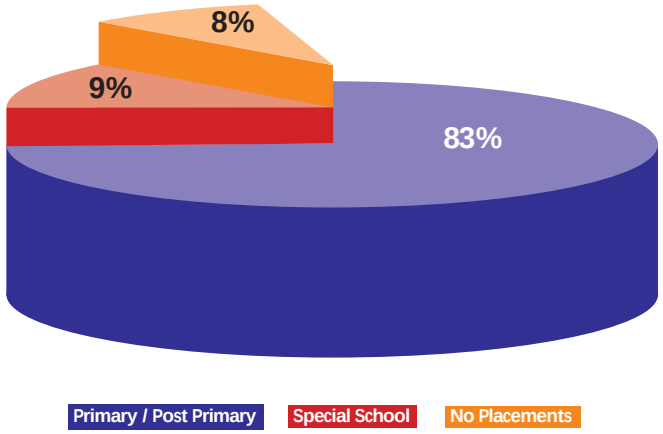
In the majority of centres inspectors found that relationships between residential workers and other professionals were good. Some were excellent. This is an important and encouraging finding as poor inter professional working is associated with poor services for children. Positive working relationships were marked by a number of key features: clarity around roles and responsibilities, clear communication, consultation and joint decision taking. Problems arose where one or more of these elements was missing.

Residential care staff liase closely with the children's families and social workers. It is of vital importance that this relationship works in the interests of the children in care. Difficulties arose most often when there was a lack of clarity about roles and responsibilities. This sometimes occurred over which professionals have the main role in maintaining contact with the families. In two centres, inspectors found very poor working partnerships between residential workers and social workers. In both cases, lack of consultation and joint decisions was detrimental to the children.

In one centre where there had been problems in communication between social workers and centre staff, the manager arranged a meeting to clarify the issues involved. This was productive. Inspectors commend this

Education Figures for Children Under 15 Years of Age in Children's Residential Centres Inspected by Social Services Inspectorate between July 2000 - July 2001

TABLE 13



approach and urge that social workers and residential child care managers jointly attend to difficulties as they arise.

Residential workers generally have less contact with other professionals such as teachers, counsellors, psychologists and child psychiatrists. Where they occurred the working relationships were generally good. There were occasionally problems in communication or understanding of roles, and one inspection report highlighted the important issue of confidentiality. One young person stopped attending a counsellor because of a perceived breach of confidentiality. This highlights the importance of clarifying and respecting boundaries for children and young people who are involved in counselling and therapy services.

5.13 Education

Inspectors found the standard of education was well met in urban and rural areas. Education is crucial for young people in care and is a key to all aspects of their lives when they leave care. The centres valued young people's education and all efforts were made to secure and sustain school placements. Responses received from teachers were very positive. They stated that care staff were supportive of all aspects of the young people's school life; they attended school meetings and events; assisted young people with their homework, and maintained regular liaison with schools.

Reference: Table 13

Reference: Table 14 (following page)

Of the 85 young people surveyed, 53 (62%) were of school going age. Forty-four (83%) of these young people were receiving primary or post-primary education. Five (nine per cent) attended special schools. The remaining four (eight per cent) young people had no school placements. These figures represent a considerable achievement when compared with other care systems.

There were a number of examples of where care staff and teachers co-operated closely in adopting a flexible approach to sustaining school placements, particularly where young people had not attended school for a long time or where young people presented with challenging behaviour. Some young people were reintegrated into the school system through one to one tuition, attendance for reduced hours, or a care worker sitting with the child in school.

Certain centres were highly commended for respecting young people's wishes to continue attending the same school as they had before being placed in care. In some instances this meant transport being supplied or organised by the centre.

Extra tuition has been made available for young people. In one centre a tutor attended the centre four days a week to assist the young people doing their homework. This resulted in a dramatic improvement in educational achievements.

Of the four young people not in school, one was receiving home tuition, a second was referred to a centre that had a school on site and the remaining two were disengaged from education or youth training options

Of the five young people unoccupied, one was seeking employment, a second was a new admission and a school place was being sought for him, and a third was receiving home tuition. The two remaining young people had difficulties engaging with either education or training programmes, despite the efforts of staff to assist them.

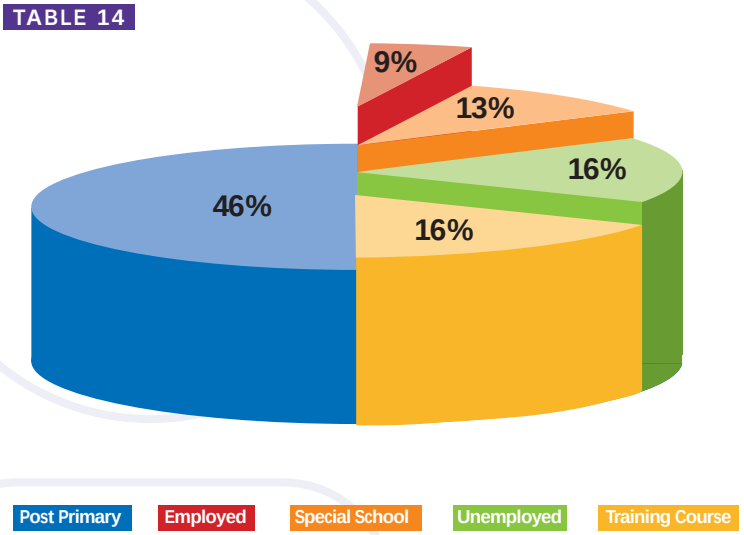
5.14 Privacy, dignity and individuality

Inspectors found that these important aspects of daily life, representing the culture of the service were of good standard in the majority of the centres. A benchmark for privacy used by inspectors was in relation to bedrooms and phone calls. In respect of bedrooms, the majority of children in the centres had their own room and were not required to share. In two centres young people had keys to their bedrooms. Young people in only two of the centres reported to inspectors that staff did not always knock and wait before coming into the bedrooms. Another issue in three centres was that bedroom doors had glass panels in them. The centres concerned were urged by inspectors to find a means of ensuring the privacy of young people in their own rooms.

In 11 centres young people had some difficulties in making phone calls either because of restrictions on whom they may phone, or more commonly, being inhibited by the location of the phone in the centre. In some instances they had to use the office phone, and in others a phone in the hallway. In only three centres did inspectors find that young people have complete privacy when using the phone although a minority of centres permitted young people to use their own mobile phones.

Occupation of Young People Aged 15 - 18 in Children's Residential Centres Inspected by Social Services Inspectorate between July 2000 - July 2001

TABLE 14



The main concern for inspectors in relation to the dignity of a child or young person was in special care units. Inspectors noted that staff had a difficult task in balancing the need for security with the dignity of the young people in relation to personal and room searches.

Generally, inspectors commend staff for promoting the individuality of young people. Memorabilia, certificates of achievement, sports trophies, and photographs are displayed and kept on behalf of the young person. Birthdays, and other key events such as first Communion and Confirmation are celebrated. However, in one centre inspectors found little evidence of who lived there, and in another keyworkers did not record ordinary life events.

5.15 Maintenance of a Register

A health board is required to maintain a register of the particulars of children placed in residential care by the board. Only ten centres inspected during the year have such registers. Of the others, four have some form of record of children in their care, but nine have none at all. Some health boards keep the information centrally in an office of the board.

This is an essential regulation and all boards must attend to it as a matter of priority. Where a board finds a gap in their records they should reconstruct the record.

5.16 Insurance

Health boards must ensure that all children's residential centres are adequately insured. This standard was met in relation to all of the centres.

5.17 Safety

Three-quarters of the centres had health and safety statements. These provided useful guidance on responsibilities, hazard control and safe work practices. However, while general advice is given in the safety statements, only one such statement was site-specific. The majority are generic statements that apply to all health board centres.

In the main premises are kept safe. Food is stored in accordance with basic rules of hygiene. Safe work practices, such as secure storage of cleaning materials and potential dangerous utensils, are observed. While a number of centres have a designated health and safety officer from the staff team, there is a general need for more staff training in health and safety and first-aid. Eleven of the centres had completed a health and safety audit. There was evidence of substantial work carried out in centres as a result of these audits, particularly in respect of medium to high risk hazards. Corrective action was still outstanding in seven of the centres at the time of inspection.

The need for repairs is promptly reported to the health board's maintenance section and while there frequently are delays in relation to non-essential work, health and safety concerns usually receive a quick response. Some exceptions were noted, including a window boarded up in a young person's bedroom while awaiting repair and a broken gate that constituted a safety hazard to a young child had received no attention for over two months.

Inspectors did note a number of individual potential hazards across centres. Some of these included carpets in poor condition presenting as trip hazards, broken sockets, broken tiles in a bathroom, exposed wires and inadequate ventilation.

Three of the centres (apart from the two centres required to relocate immediately due to fire hazards), were of particular concern to the inspectors. One centre was unable to implement the recommendations of a health and safety audit, as it was a leased premises and the letting agent would not agree to the necessary work. The inspectorate acknowledges that boards can experience difficulties convincing landlords of the need to carry out repairs/adjustments. However its paramount duty is to the young people in its care, and in such cases alternative premises must be secured. The two other centres had hazards noted in their safety audits that had been unattended. While in both cases the boards planned to relocate the centres to more suitable premises, this does not discharge them from their present duty to expedite essential repairs to ensure the safety of young people in their care.

5.18 Fire Precautions

Fifteen centres had a fire certificate or written confirmation that all statutory requirements relating to fire safety have been complied with. Another centre had an interim fire certificate pending a final inspection by a consultant

engineer. Seven centres could not produce such confirmation.

Following inspection by SSI two of these centres were required to relocate to alternative premises immediately as they presented an unacceptable level of risk to all occupants. In both cases the boards had been previously informed by their own officers that they could not certify the safety of the building without extensive remedial action. A third centre was unable to meet the safety conditions necessary to acquire a fire certificate, as the property was leased and the letting agent would not approve the necessary changes to the building. SSI recommended that the centre was relocated to a property approved by the board's fire officer and this is currently being pursued. A further centre still had outstanding matters to attend to in relation to emergency lighting as advised by the board's fire officer. These were rectified following inspection. Specific concerns in relation to other centres included a hazardous fire escape route in one centre and fire escape doors being locked in respect of three centres. Recommendations to rectify these matters were made to the relevant boards.

Some overall improvements in relation to fire safety have however been noted. These include fire drills, training in fire safety and evacuation, and records of maintenance of fire safety equipment. However there is still room for improvement. Six centres still require training in fire safety; three centres do not hold fire drills and three others have only held one each; and a further three centres could not show that fire equipment was being adequately maintained.

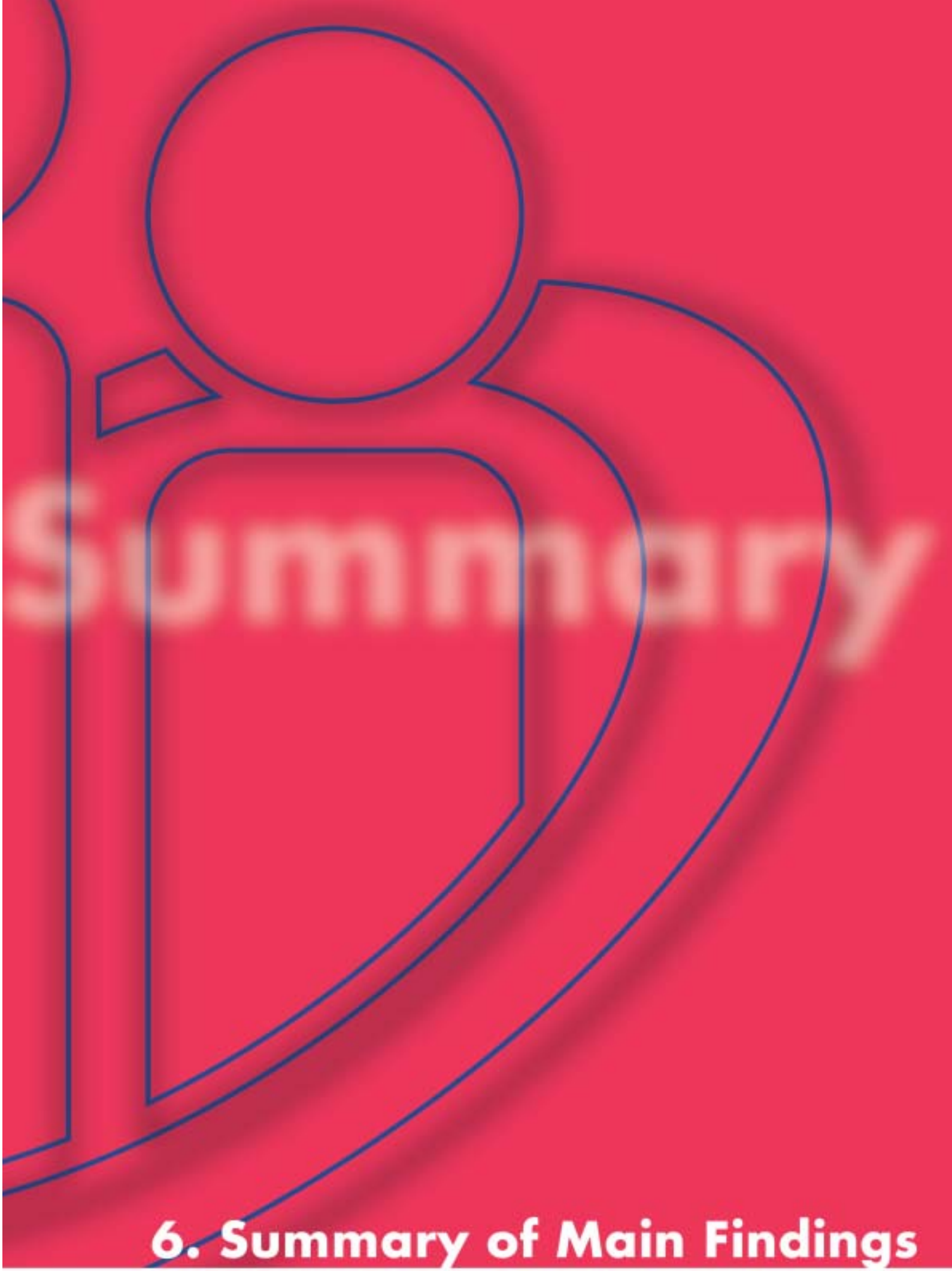
5.19 Administrative records

A number of administrative records were common to all centres. These include a communications book, daily log books for each young person, records of the use of sanctions, unauthorised absences, incidents/ significant events, dispensing of medicine, and TCI records.

In general recording systems are organized and maintained to facilitate effective management and accountability. Care staff are clear about the purpose of making the record and know when and how they should do so. Entries are up-to-date, legible, generally signed and dated. They are stored securely and confidential information is protected. Care staff show diligence in respect of routine administrative recording.

However, inspectors noted, in respect of 8 of the centres that to varying degrees discrete records were not kept of the use of physical restraint, sanctions, unauthorised absences and significant events. The practice of recording all events in the daily log book does provide a useful system of internal communication, enabling care workers to access easily what has been happening in the centre. However, in the absence of discrete records it can be difficult to form an overall picture of significant events such as the use of physical restraint, complaints, sanctions or unauthorised absences and to identify patterns of behaviour that could usefully inform practice in relation to individual children. Discrete records also play an important role in monitoring centre practice.

All administrative records, particularly significant events, should be read and signed by centre managers at regular intervals. While the inspectors were informed that this is practice they did not find evidence to confirm this in all instances. Records of significant events generally record the young person's name, details of the incident including the actions of the young person and staff involved, details of the people informed of the incident and the signature of the staff making the record. The usefulness of these forms would be enhanced, if in all cases, they included a section for the centre manager to comment on the incident and make recommendations. In addition, incident sheets should record the dates and times when parents, social workers and line managers were informed. These details were omitted in a small number of instances.



6. Summary of Main Findings

6. Summary of Main Findings

6.1 Overview

Since the publication of Report of Findings Relating to Inspection of Children's Residential Centres in October 2000 the Inspectorate has found that in 23 subsequent inspections many of the standards for children's residential care are well met and work on improving others is ongoing. However, some standards are still not observed. Furthermore the standards are applied unevenly across the country. The increase in the number of centres and special arrangements also deserves analysis.

Readers of this report will be aware that good practices are evident in many areas. Consistently, inspectors found children and young people had warm and caring relationships with their carers and high standards of care regarding their health and education. Centre staff had positive working relationships with the families of children in their care and with other professionals. Awareness of children's rights had improved as had written policies to guide staff in their practices in the centres. Inspectors noted that where practice has to be improved, centre managers and staff are open to recommendations and guidance.

These and other examples of good practice were discussed at the conference jointly organised by the DoHC, Health Boards and SSI held in Athlone in September 2001. That conference endorsed the benefits of highlighting best practice and building on what works. SSI continues to support this approach but has a responsibility to point out areas that need specific improvement. Some recommendations from reports can be implemented quickly while others will take longer. Following the publication of the Report of Findings Relating to Inspection of Children's Centres the Chief Executive Officers (CEO) of the health boards set up the National Advisory Group for Residential Care to review its findings, identify the critical issues for health boards, and develop strategies to ensure they are addressed. Progress has been made on issues of definition, notification of new centres, pre-opening inspections and the health board role in monitoring children's residential services. SSI commends the work of this group and urges the boards to keep residential child care, as with other alternate care arrangements, a priority for all boards until widespread satisfactory standards are achieved. The attention given to residential child care is evident by the improved management structures put in place by some boards and the monitoring arrangements made more generally. As this report shows, the impact of the monitor has yet to become evident in all but a minority of areas thus far.

In the past year, DoHC published National Standards on Children's Residential Centres and issued Standards for Special Care. The DoHC and the health boards have established a project team to devise proposals for the establishment of a national standardised integrated child care information system. In this context consultants have been contracted to develop a national standardised information system. Additionally, the Implementation Body of the Child Care Worker aspects of the Report of the Expert Group on Various Health Professionals (April 2000) is working on its recommendations. The pay agreement for this sector introduced in the Spring of this year, should assist boards in recruiting and retaining qualified staff. These developments will contribute significantly to the overall progress in improving standards.

The Inspectorate found that, overall, inspections continued to be welcomed by managers and staff alike. Although the process can be difficult, feedback from boards and centres has indicated that the spotlight of attention, externally from SSI and internally from within the board, is helping to raise standards.

The areas to which boards are urged to pay significant attention are: strategic planning; recruitment, retention and qualification of staff; care planning; specialist support for children and young people, after care, and implementing inspection recommendations.

6.2 Strategic planning

Like all organisations delivering services, child care residential services need to be planned strategically and delivered well. Health boards should have a range of services available to meet both the long term and the emergency demands made on the child care residential services. This may mean changing the purpose of some centres in order to increase the range of service available.

Demand for children's residential services represents one part of overall delivery of services and increased demand in this area could indicate a crisis in some other part of the system. Boards need to have a sufficient number and range of residential places, as a percentage of their alternative care provision, to cater for the needs of their population.

Inspection findings and information gathering have shown a major increase in emergency provision in some boards. Many inspection reports comment on the disruptive nature of emergency placements where this has not been provided for as part of the work of the centre. The number of inappropriate placements of very young children, although small, is clearly unacceptable. Over one third of children in this round of inspections of children's residential centres were under 12 years and this is a worrying trend. It is unlikely that this type of care was deemed first choice for this entire group. This report has already noted concerns about the development of special care arrangements and the SSI is confident that if overall planning was developed the demand for special arrangements would decrease.

Where children's residential services are community based, and there is little support for staff or individual young people it is likely there will be crisis and discharges and transfers of children whose needs remain unmet. Boards need to provide assessment and specialist support to community facilities so as to identify and work with children and staff before a crisis develops. When a centre has an agreed purpose and function this should be preserved by adhering to agreed admissions procedures, care planning and adequate resources for discharge plans to be effective. Inspection findings establish that centres with a clear purpose and function, expressed in day to day care practices, generally deliver high standards of care.

Several boards have developed or are in the process of developing strategic plans. There are examples of impressive developments in the range of available services. The Inspectorate is aware that in a minority of boards, residential child care has been operating at a crisis level and new developments are reactive to short term needs resulting from a crises or emergency. These boards are advised to review their alternative care services and identify priorities.

6.3 Recruitment, retention and qualification of staff

The difficulties associated with the recruitment, retention and qualifications of staff highlighted in last years report continue to be of concern. All boards have reported difficulties in recruiting qualified staff.

The Implementation Body on the Child Care Worker aspects of the Report of the Expert Group on Various Health Professionals is urged to complete its work to support the development of the child care profession. Some health boards have arranged with local Institutes of Technology to provide courses for existing staff. The development of national guidelines on related qualifications and prior experience would assist health boards and educators in providing qualifying opportunities for all staff.

Many boards are recruiting child care staff abroad, from Europe, Canada, South Africa, Australia and New Zealand. Individual boards are making decisions regarding the standard of qualifications gained abroad. A central body should be charged with examining all qualifications of people applying to work in the area of child care in this country and ratifying those that are acceptable.

Inspectors found unacceptable numbers of staff on temporary contracts around the country and recommend that boards look at measures to retain their existing staff, as well as recruit new staff. Staff are more likely to stay if they are offered permanent contracts, in-service training, a career structure, and on-going opportunities for professional qualification opportunities.

6.4 Social work role and care planning

Social workers play a vital role in the life of a child placed in residential care. They are responsible for preparing a care plan, finding a vacancy in a centre, placing the child there, arranging for statutory reviews, working with parents towards the return of the child or maintaining ongoing contact, keeping in touch with all the people important for the child, and visiting the child regularly and making sure they are safe, happy and their needs are met.

The inspection findings show that social workers visit children and arrange review meetings regularly. There were serious shortcomings in the area of preparation of care plans, as outlined in Article 23 of the Child Care Regulations 1995. The Inspectorate understands that there

are serious shortages of social workers in some community care areas but this does not explain the lack of care plans as the proportion of children with an allocated social worker well exceeded the number of care plans. The existence and quality of the care plan seemed more dependent on the expectation and leadership shown by the principal social worker or child care manager in the area.

The MWHB has received funding to undertake a three year Care Planning Project, to start this year, with the aim of developing a new model of care planning. Early findings or material developed will be shared with other boards as they occur. While SSI commends this development, it does not relieve social workers of their statutory responsibility to develop care plans for children for whom they are the supervising social worker. Other boards, including most recently the NAHB, have developed care plan formats to assist their social workers carry out their duties. Social workers operating without a specific board policy on care planning are urged to read and use the regulations in developing a care plan while awaiting national guidelines.

6.5 Specialist support for children and young people

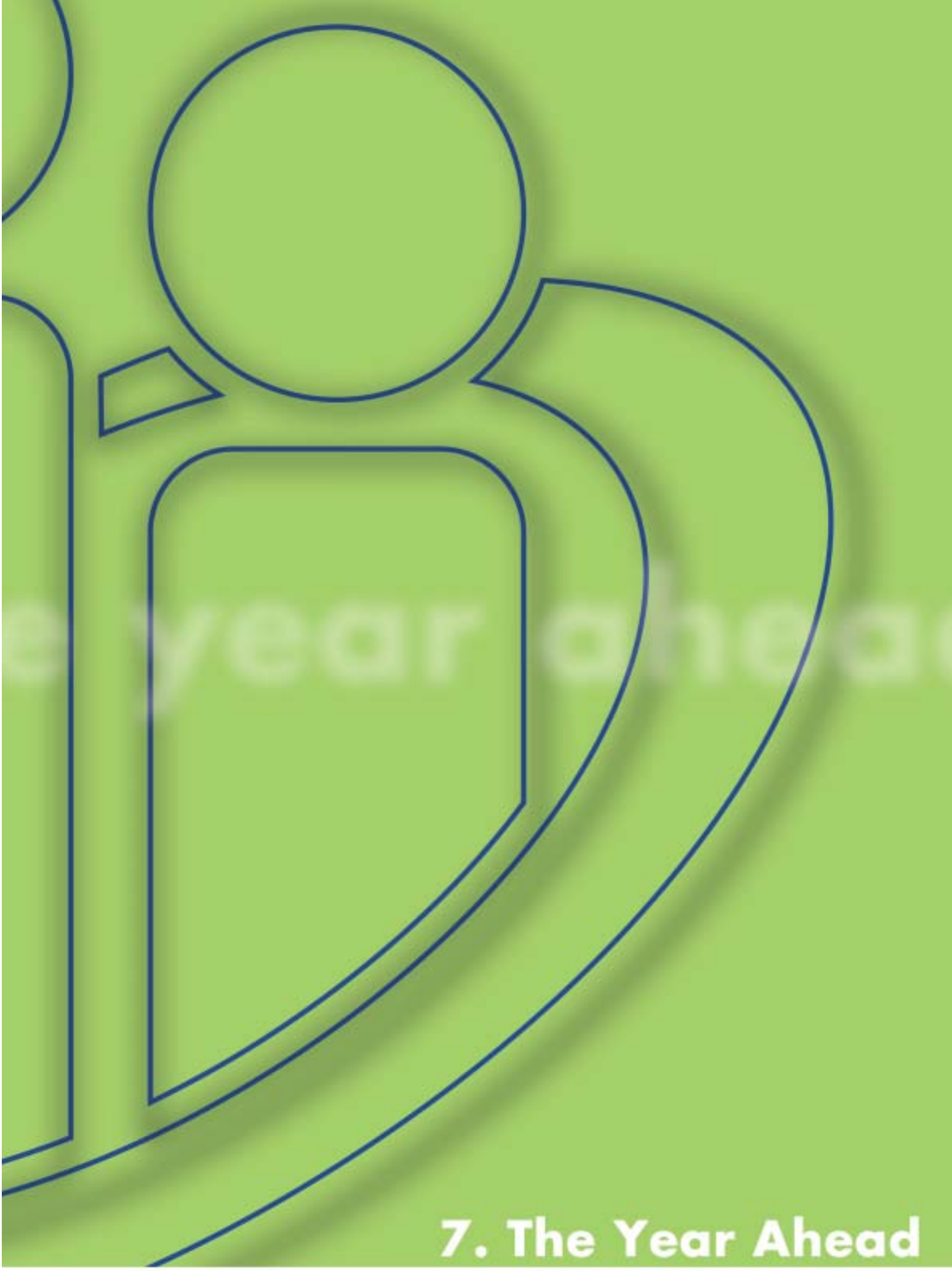
Over half the centres inspected reported difficulties in accessing specialist support for the children in their care. Not every child or young person living in a residential centre either wants or needs to see a child specialist but all staff groups benefit from opportunities to develop their understanding and skills in working with children who have encountered loss and trauma. There is a small group of children who need specialist assessment and support to help them deal with their experiences and feelings. Without this service these children can remain profoundly troubled, and in time, prove themselves to be profoundly troubling to their carers. The boards should prioritise the provision of specialist services.

6.6 After care

Inspectors have come across a small number of examples of dedicated after care services set up in board areas to support young people in their transition from care, and these are commended. However, the majority of inspections show that although many young people preparing to leave care and in after care have good informal contact with care workers and the centres in which they lived, there has been little development by boards of formal support services to assist young people leaving care, either to return home or to live independently. Research has highlighted the extent of difficulties young people leaving care frequently experience. Health boards should develop appropriate support services to assist young people on their transition to adulthood.

6.7 Implementation of inspection recommendations

Health boards are required to make a written response to the DoHC following inspection reports. The rate of response has been low. It is unclear at this stage if this means that recommendations are not being implemented or that a written action plan has not been forwarded to the DoHC. A new inspection follow-up process has been agreed and this should improve the situation. Boards are reminded to send an implementation plan detailing how all recommendations made in inspection reports are to be implemented to the DoHC. The value of inspections can only be judged by the impact of recommended changes on the lives of children and young people.



7. The Year Ahead

7. The Year Ahead

7.1 Inspection plans

SSI plans to continue its inspection programme of children's residential centres. As new centres and special arrangements are being set up and more established centres transferred from the non-statutory sector to health board management the number of centres on our inspection list has increased.

When all centres have been inspected once, SSI will review the inspection format, and will consider if theme or cluster inspections should be a more regular feature of future inspections. Additionally, a detail review of the implementation rate of all recommendations made will be undertaken. Where there have been difficulties or delays in implementing recommendations, inspectors will undertake an analysis of the reasons.

7.2 Completion of National Standards for Foster Care

The target for publishing fostering standards is during 2002. In advance of inspection, SSI will meet with a range of service providers and service users to introduce the standards and the inspection process. It is the aim of SSI that the published standards will support the development of quality services and that, in advance of inspection, the standards will assist health boards in an exercise of self-evaluation that will identify problems and indicate solutions.

7.3 Implications of the Children Act, 2001

Section 267 of The Children Act 2001 amends Section 59 of The Child Care Act 1991, so that residential centres for children with a disability become subject to inspection as set out in the 1991 Act. Centres run in the non-statutory sector are subject to the registration and inspection requirements by health board inspection teams, and those centres run directly by health boards will come under the direct inspection remit of SSI.

It is essential that services in all ten health boards, in the statutory and non-statutory sectors, are inspected against the same standards, and that those are applied consistently across geographical and organisational boundaries. It will be necessary for standards to be developed and for the SSI and health board R&I units to work closely to develop similar inspection processes, levels of recommendations, and accessibility of reports. Active consideration should be given to co-ordinating inspections with the Department of Education and Science (DES) where there is a joint responsibility.

7.4 Guidance notes

Following on the four guidance notes published earlier this year, SSI will continue to publish guidance on key issues. In time these will be collated and published as guidance to the standards. The topics selected will continue to be based on findings from inspection reports where boards are experiencing difficulties.

7.5 Unannounced inspections

Now that the inspection process is well established, SSI will undertake, from time to time, unannounced inspections. These may be either a full inspection or an inspection of certain key policies or practices. The purpose of the unannounced inspection is to satisfy that the standards are in place when an inspection is not expected.

Managers, staff and children should not be any more anxious about an unannounced inspection than an announced one. Inspectors are all familiar with the everyday reality of children's residential care and the context of events on the day will be taken into account in forming judgements. The daily routines and special plans made for children will as always be respected and children will be invited, and never obliged to talk to inspectors.