

**REPORT OF
FINDINGS RELATING TO
INSPECTION
OF
CHILDREN'S RESIDENTIAL CENTRES**

IRISH SOCIAL SERVICES INSPECTORATE

Floor 3, 94 St. Stephens Green, Dublin 2, TEL: 01-4180588, FAX: 01-4180829

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1 Overview of Social Services Inspectorate

1.1 Introduction

The authority for inspection of children's residential centres run by the health boards is contained in the Child Care Act 1991, Section 69 (2), which states that "The Minister may cause to be inspected any service provided or premises maintained by a health board under this Act".

The Irish Social Services Inspectorate (SSI) was established for the purpose of such inspection in 1999. An Assistant Chief Inspector from the Social Services Inspectorate in Northern Ireland was seconded, on a part time basis, to assist the Department of Health and Children with its development. A small team of three inspectors was recruited in September 1999. After a period of induction training and the development of draft standards for residential child care, which involved discussions with representatives of the health boards and the voluntary sector, a pilot inspection was carried out in a children's residential centre in the South Eastern Health Board area. With some modification, in light of the pilot experience, the draft standards were adopted and issued by the Department of Health and Children as the standards for children's residential centres run by the health boards. It is these standards that have been used as the basis for inspections.

Under the Child Care Act 1991, Sections 61-63 provide for the registration and inspection, by health boards of children's residential centres run by the voluntary sector. It has been noted that a number of organisations operating centres in the voluntary sector are withdrawing from the provision of residential childcare services. In many cases where this has occurred responsibility for the running of the centres concerned has transferred to the health board. Consequently, the number of children's residential centres subject to inspection by SSI is increasing. The inspection programme will continue until all children's residential centres run by the health boards have been inspected.

The purpose of this report is to provide initial feedback to the Minister, the health boards and the public about the quality of care being provided in those children's residential centres that have been subject to inspection so far. It is not intended in this report to identify specific centres (this information can be obtained by reading the inspection reports which have been prepared on individual centres) but rather to give an account of the general state of the services inspected and to highlight emerging issues that require to be addressed by health boards. Action on these matters should foster the development of more efficient and effective services, which in turn, should result in the centres being more responsive to the needs of children.

1.2 The Inspection of Children's Residential Centres

The first round of inspections has entailed inspection of centres in each of the health boards. The centres inspected in the first round have included a high support unit, a special care unit and a hostel for homeless young people in addition to a number of residential units for medium/long term care of children and young people.

The centres inspected were:

- St Joseph's, Kilkenny (Avondale and Crannog units) (South Eastern Health Board);
- Ti na nOg, Navan (designated as a high support unit) (North Eastern Health Board);
- Brookwood, Dublin (Northern Area Health Board);
- Tallaght, Dublin (South Western Area Health Board);
- Auburn, Ballymahon, Co. Longford (Midland Health Board);
- Bartres, Dublin (South Western Area Health Board);
- The Haven, Limerick (hostel/homeless young people) (Mid Western Health Board);
- Aras Geal, Salthill, Co. Galway (Western Health Board);
- Gleann Alainn, Glanmire, Co. Cork (a special care unit) (Southern Health Board);
- Lios na nOg, Ballytivnan, Co. Sligo (North Western Health Board); and
- The Vineyard, Rathdrum, Co. Wicklow (East Coast Area Health Board)

Additionally, a second centre in the Northern Area Health Board (Blaithin), was inspected but not included in the statistics quoted in this report.

A survey by the Department of Health and Children in 1999 found that there were 106 children's residential centres in Ireland, of which just under half (49) were run by the health boards. The remaining 57 centres were run by the voluntary sector, which has traditionally been the main provider of residential child care services in Ireland. Between them the health boards and the voluntary centres provided places for just over 700 children and young people. Two hundred and seventy nine (279) of these places were provided within centres run by the health boards with the other 462 in the voluntary sector. Children's residential centres run by the voluntary sector are funded by the health boards in whose areas they are located. Voluntary centres are subject to inspection by the health boards and for this purpose some health boards have appointed their own inspectors. The Social Services Inspectorate (SSI) receives copies of the health board inspection reports on voluntary sector centres in order to monitor the standard of care being provided in those settings. At the time of writing this report 14 such reports have been received. SSI has been meeting with health board inspectors over the past few months to try to ensure a consistency of approach to inspection of centres in the voluntary and statutory sector and some joint training sessions have taken place.

1.3 Follow up to the Findings of the Inspectorate's Reports

SSI is operationally independent from the Department of Health and Children and produces its own reports on the inspections it has carried out. Agreement has, however, been reached with the Department on how the findings and recommendations of its inspection reports are to be taken forward. Completed inspection reports, as well as going to the health board concerned, are also sent to the Department who seek from the health boards concerned their initial response and an outline of their proposals for implementing the recommendations contained in the reports. The boards' responses are then copied to the Inspectorate who note the action being taken or being proposed. Should there be concern about any particular centre the inspectorate reserves the right to carry out a follow up inspection at an appropriate stage to ascertain whether necessary action has been taken and to determine whether there has been an improvement in the standard of care provided.

1.4 The Process of Inspection

This overview report is based on the findings of inspections carried out in 12 children's residential centres in the statutory sector, already listed. Each inspection was carried out by a team of two inspectors, who spent a period of 3 days in the centre concerned. Inspections involved a preliminary meeting with managers and staff of the centre and a further meeting separately with the children/young people resident at the centre, to explain the purpose of the inspection and the methods and approach to be adopted during the inspection. The methods employed for inspection have included:

- examination and analysis of policy and procedures documents;
- examination of various records kept at the centres (some of the material is analysed in advance of the fieldwork for the inspection);
- examination of individual case files relating to the care of the children;
- interviews with the management and staff of the centres, social workers and other professionals closely associated with the care and development of the children;
- interviews with the children themselves, and, where possible, taking the views of parents;
- observing practice in the centres;
- inspecting the premises with a view to ascertaining whether they were providing suitable accommodation for the children.

The performance of the centres was measured against the standards outlined in the document entitled "*Standards and Criteria for the Inspection of Children's Residential Centres*" issued by the Department of Health and Children in 1999. The standards are based on the requirements of primary legislation and regulations, as well as findings from research and current knowledge about best practice in residential child care. They are supported by a series of criteria, which, if satisfied, would indicate that the standard is fully met. In practice, many of the standards are not yet being fully met but it is clear that most centres are making substantial efforts to improve their practices and the standards and criteria provide a useful template for those seeking to raise standards in residential child care. The main standards cover such matters as the premises, purpose and function, health and safety, management and staffing, planning and review arrangements for care of the children, the quality of care provided, children's rights, child protection, education and vocational training, health care and health education, exercise of control, record keeping and the extent of parental involvement in the care and upbringing of the children. Each centre received a set of these standards in advance of the inspection. The standards have been widely welcomed by those responsible for the operation of residential child care services.

1.5 Child Protection Issues

It is recognised that following the screening of the *States of Fear* programmes on RTE last year there is much public concern about what has happened to children in residential establishments in the past. There are various residential establishments for young people, such as industrial schools, reformatory schools, remand centres, centres for children with

disability and child psychiatric units, which are not subject to inspection by SSI. This report relates only to children's residential centres run directly by health boards. Amongst other things it addresses issues of safety and child protection. A number of procedures have been instituted which result in children in residential care having greater contact with their parents and others in the community. The centres are now smaller, more akin to family homes and much less institutional in nature. There are also complaints procedures in place in some centres that will enable children who are unhappy with any aspect of their care, to have their concerns investigated. However, the complaints procedures were not completely satisfactory in all centres and there needs to be further development of such mechanisms to ensure that children in residential care are aware of and confident in the use of the procedures. As the procedures required by the *Children First* child protection arrangements are put into effect the public should be better reassured that the abuses of children which have taken place in the past are less likely to be allowed to occur in centres run directly by the health boards. Substantial efforts are being made to ensure there is more integration with the local communities where centres are located although local residents are not always welcoming of the presence of a children's residential centre in their area. Most importantly, increasing attention is being given to children's rights, which enables children to have a greater say in the care they receive and makes them less vulnerable.

2 Inspection of the Service

2.1 The Children and Young People

The 12 centres inspected had places for 61 children. There were 56 children in residence when the inspections took place. The ages of the children in these centres ranged from 4 to 18 years, with most of the children falling in the 11 to 17 year age range. Only three of the children were less than 10 years of age (4, 8 and 9 years). Normally, younger children in the care of the boards are placed with foster carers in the community wherever possible unless there is a plan to avoid breaking up a sibling group who have been received into care together. Some of the young children were in residential care because of a lack of foster homes and were placed in centres catering for teenagers.

Almost half of the children in the centres were in care under voluntary agreements between the board and the parents; most of the remainder were in care under formal care orders while a very small number were wards of court and one was the subject of a high court order.

Nearly 60% of the children had been in their current placement for under a year but just over a quarter had been in their current placement for periods in excess of three years. Thirteen percent had been in their current placement for periods of between one and three years.

Well over half the children (57%) had previously been placed in a foster care situation, which had not worked out. A significant number (49%) had previously been placed in another residential child care centre or in supported lodgings (some had been fostered and subsequently placed in another residential centre before coming to the centre in which they were residing at the time of the inspection). Only about 17% of the children had not previously been placed in some form of residential or foster care arrangement. These children generally came straight into care from a troubled family situation, often as emergency admissions.

2.2 Staffing

2.2.1 Recruitment and Induction

Staff are the most vital resource in providing quality care. The provision of good residential child care depends on the availability of competent, caring men and women, who are able to fulfill their duties in a humane, committed, efficient and professional manner. They need to exercise integrity and be capable of conducting themselves at all times in such a way as to gain the respect of the children so that they can provide them with a positive role model and perspective.

Recruitment plays an important a part in determining whether services will be of a high standard. The recruitment of residential care staff to permanent posts is the responsibility of the personnel section of the relevant health board. Permanent posts are subject to open competition and applicants are subject to panel interview. They are required to complete

an application form and provide references and evidence of qualifications, which are checked. Before appointments are confirmed applicants are subject to a criminal records check through the Garda Síochána. Randomised checks of personnel files by inspectors confirmed that these procedures were generally being followed although in one centre no references were found for one member of staff. In the Eastern Regional Health Authority staff recruitment for permanent posts in all units is done centrally. Successful applicants are placed on a panel and then allocated to centres where there is a staffing requirement. In this way applicants may not be placed in the centre of their choice.

There was found to be great variation in the amount of staff turnover between the centres. Whilst a few centres had a settled group of staff, there was a small number of centres with high rates of staff turnover. Recruitment difficulties at local level have led to some full time posts being filled by part time staff on a temporary basis. This was particularly evident in respect of three centres. In one of these centres, 15 different relief staff had been used to provide cover over an eight-month period. In the other centres similar patterns had emerged. In one of them the effect of this arrangement was that there were 30 different people working with the children over a three-month period. It is unsatisfactory that so many staff in children's residential centres are employed on a temporary basis. The creation of a stable residential care workforce in each centre is essential. It is clear that in many centres the current staffing arrangements are far from satisfactory. The residential child care scene appears to be characterised by a lack of permanence. Staff recruitment and retention is an on going issue for the health boards. The high level of turnover in some centres is not conducive to good care practice for children and young people who need consistency of care and stability in their lives. In the centres inspected it was noted that overall 40% of the staff working on a full time basis were on temporary contracts. The position varied from centre to centre with the majority of staff in some centres being on temporary contracts. In only two centres were all of the staff on permanent contracts. In two other centres over 80% of the full time staff were on temporary contracts.

All temporary staff are recruited by interview, which is usually carried out by the centre manager or house parent and line manager. In some instances recruitment has been through public advertisement in national or local newspapers, in some it has been through the consideration of curriculum vitae submitted to the personnel section by interested persons and in a few cases through people having heard of vacancies by word of mouth. Nevertheless, staff recruited on a temporary basis are also vetted. This is done through the taking up of references and criminal record checks. SSI inspection of a selection of staff records, however, identified that in three of the centres there was no evidence of a criminal record check by the Garda for temporary members of staff.

The inspections revealed that the induction training of new staff could be improved. In the absence of a formal induction programme some new members of staff appear to receive only details of house routines. More often, new staff are given an 'induction pack' and shadow an experienced member of staff for a period. A formal induction programme would be helpful in ensuring that new staff were clear from the start as to what was expected of them. Such a programme could outline the purpose and function of the centre, the ethos of care and all the policies and procedures that exist to inform

practice, including particularly those that relate to child protection and to health and safety.

2.2.2 Staff Experience

Length of service in the different centres varied considerably. Some centres had staff with long experience in the centre while in some others the experience of the staff was very limited. Those centres that had previously been managed by voluntary organisations tended to have experienced staff groups while centres established directly by the health boards tended to have less experienced staff.

Of the centres established by the health boards, which had been in operation for at least 5 years, three had between 50-60% of staff with less than two years experience in the centre. In one of these centres the majority of the staff had less than one year's experience of residential child care work, with the longest serving member having only been in the centre for 2.5 years. The availability of people with experience of residential child care is a problem for boards seeking to establish a high quality residential child care service.

2.2.3 Qualifications and Training

The Department of Health and Children has determined the qualifications for house parent posts. It was noted that overall, 41% of all full-time staff had recognised qualifications for residential child care. The position, however, varied greatly between centres with three centres having between 80-90% of full-time staff holding recognised qualifications and five having between 40-50% of staff qualified. In the other four centres, however, only a small proportion of the staff held the recognised qualifications.

It was noted that in most centres the majority of care posts were designated as assistant house parents, for which there is no specific professional qualification required. Some centres had only one house parent with all the other care posts being designated as assistant house parents. This was the most common pattern. There were, however, two exceptions to the general pattern; these were in one centre where there were 11 house parents and 5 assistants and another where there were 4 house parents and 4 assistants. The difference of role between the house parent and assistant house parent was not always clear to inspectors. It was evident that the role carried by assistant house parents in one centre was similar to that carried by house parents in another centre.

Although a substantial proportion of care staff do not have the recognised qualifications for residential child care, it is encouraging to note that they do have between them a wide variety of other educational and vocational qualifications, which are undoubtedly useful to them in their work with children. The qualifications include degrees in subjects such as social science, psychology and social psychology as well as diplomas and certificates in counselling, child protection and welfare, youth and community work, sports leadership, applied social studies and a range of nursing qualifications including general, psychiatric and mental handicap nursing. The distribution of these qualifications again differs across the centres. One centre has a substantial proportion of graduates while several centres have some staff with no qualifications.

Whatever the position on qualifications there is a need for care staff to have opportunities to further develop their knowledge and keep themselves up to date regarding new information about ways of working with children. Many centres do provide such opportunities and it was clear that many had access to and utilised in-service training provided by the boards. Examples of such courses included *Solution Focused Therapy, Bullying in Residential Care, Freedom of Information Act, Child Abuse, Sexuality and Health, Domestic Violence and Developing Staff Potential*. Many staff identified the need for training and on-going support in addressing young people's emotional and psychological needs. While in most centres individual members of staff are generally encouraged to attend in-service training courses, inspectors found an absence of any systematic approach to identifying and addressing the training needs of individual staff. There are undoubtedly new demands being placed on residential child care staff. Most staff had received training in therapeutic crisis intervention. Inspectors have, however, also identified the need for more focus on training in such matters as care planning, child protection, child and adolescent development, working with families, children's rights and in ways of involving young people in decisions affecting their lives.

A further point to which the inspectorate's attention has been drawn is the question of the adequacy of existing professional training for residential child care. Consideration should be given to whether the curriculum for these courses is adequate to prepare students for the role currently required of residential child care staff and whether the practice placement experience provides appropriate learning opportunities.

2.2.4 Supervision

Residential work with adolescents can be demanding and, at times, stressful. Regular supervision of care staff by the unit manager or house parent, where appropriate, is a necessary means of providing support as well as identifying strengths and weaknesses in performance and areas of practice that need to be improved.

The range of supervision offered varied across the centres with no formal supervision being provided for staff in about a third of the centres. Only a few managers provided regular supervision and in only two centres was there a written record of this. In four centres formal supervision had just recently been introduced with all staff in those centres having had at least one session. While most managers acknowledged the value of supervision for staff it was not uncommon to find that it did not happen as frequently as it should. Reasons offered were the practical difficulties of workloads, changes in management personnel and the need for managers themselves to have training in supervision methods. Regular, formal and structured supervision is a key element in ensuring that staff performance in the provision of care is kept at a high level and slack practice is not allowed to develop. Greater priority needs to be given by residential managers to the provision of regular supervision of staff.

Residential managers themselves should have access to support from their line managers. Support arrangements for residential managers were variable with some meeting their line managers on a 6 weekly basis while others met on a 6 monthly basis. Arrangements had been made for some residential managers to have formal support from an outside

professional such as a child care manager or a consultant psychologist in addition to line management supervision. In a few situations there was no formal supervision available at all but in these situations there was at least informal support from line managers, child care managers or the general manager. Managerial oversight of the work of a centre can be assisted through regular consultation between the residential manager and the line manager and the inspectorate has advocated that more attention be given by line managers to convening regular formal meetings for discussion about the progress of work in the centre and to provide direction.

2.2.5 Duty Rotas

The planning and structuring of staff duty rotas is important in ensuring there are sufficient numbers of staff on duty, particularly at times when young people are in the centre and when there is opportunity for care work to be undertaken with them. Staff also need time to perform professional duties which support the work such as planning, report writing, updating case files, preparing for and attendance at review meetings and spending dedicated time on key worker duties working with children. Although different centres operated different systems, some a 24/25 hour shift pattern, others with 6 or 12 hour shift patterns, in general, rota duties were organised in a manner which enabled appropriate cover. Centre managers had the flexibility to be able to vary the number of staff according to needs of the children. Care needs to be taken to ensure that staff are not required to work unduly long shifts, which could result in them being tired when the demands of children necessitate their being alert and fresh.

One centre, which had eight residents, had provision for a separate day shift to facilitate the completion of key worker tasks. This shift was set aside for key workers to complete specific duties in relation to the children for whom they had special responsibility.

2.3 Premises

The first round of inspections covered a range of residential child care provision. In contrast to the accommodation described in the States of Fear programmes children's residential centres run by the health boards are now much smaller units and tend to be more domestic in design. Most of them provided a home that was suitable for children although one or two of them were cramped for space, which limited some aspects of the work that could be undertaken. The space limitations of the hostel for homeless boys placed many restrictions on the work it could carry out and the inspectors considered the premises it occupied as basically unsuitable for its purpose. The board concerned had acknowledged this and was seeking to find alternative accommodation. Most residential centres were situated near to local amenities such as schools, youth clubs and shops and most were convenient for public transport.

The average number of children per centre inspected was 5. Even the largest one, St Joseph's Children's Residential Centre, Kilkenny, which provides accommodation for up to 14 children and young people has been divided into two distinct centres that are at quite separate locations. The smaller centres, in keeping with modern thinking about the best way to provide good residential child care, allow for the needs of individual children to be identified and dealt with more appropriately.

One of the units, a centre for up to five girls, was located in a hospital complex in an older building which formerly accommodated TB patients and was institutional in appearance. While it was clear that there would be limits to the extent to which the institutional appearance could be changed, renovations were planned to refurbish and upgrade the unit to enhance its appearance and make it more suitable for young people.

Generally, inspectors found most of the centres provided the children with a welcoming environment and it was clear that most of them were places where staff encouraged parents to visit. Most of them had recently been decorated or were in the process of being redecorated. One or two were in need of redecoration but there was evidence that where redecoration was required this was being planned. In most centres children had their own bedrooms although in two centres it was necessary for some children to share a room with another. In most centres children had personalised their rooms with photographs, posters and memorabilia so that their rooms mirrored what one might expect in a typical teenager's room in a family home. This was not, however, the case in the one special care unit we inspected, where efforts were required to make the environment more suitable for young people, albeit within the constraints imposed by security.

While all centres were good at providing for and supporting young people's outside interests, indoor activities were limited in some of them. There was need for improvement in the provision of play and recreational facilities in such centres. Four of the centres did not provide sufficient privacy for visits or telephone calls. The other centres provided adequately for this and in two of those that did not, consideration was being given to ways in which greater privacy could be better respected.

2.4 Purpose and Function

The standards issued by the Department require each centre to have a statement of purpose and function that accurately describes what the centre sets out to do with the young people and the manner in which this is to be provided. A clear definition of purpose and function is fundamental to the successful management and operation of a children's residential centre. The policies and practices of the centre should reflect the statement. The statement should be available for the guidance of staff, referring social workers, parents and children and others with an interest in its work.

Inspectors found that all centres had a statement or draft statement of purpose and function. However, they considered some of the statements to be of limited value because they were not placed in the context of their board's overall child care policy and some of them did not refer to the existence of specific policies and procedures for the particular centre. Some of the statements related to the residential child care service of a board and were the same for all centres in the board's area. These statements did not identify clearly the specific functions to be carried out by any of the centres. Many were in the early stages of developing a statement to guide their work and the existing statement of some of them did not reflect the current practices in the centre.

Statements were generally located in a centre's policy and procedures manual. They usually had a comment about the ethos of care that the centre aimed to provide and the

gender and age of the population. It was unusual to find a statement that provided a clear outline of the type of placement that the centre offered. For example, most did not indicate whether they were providing short, medium or long term care. Neither was it usual for a centre to indicate whether it was aiming to carry out assessment or provide a treatment based service. In part, this reflects the multiplicity of tasks that many centres undertake. The stated purpose of a centre was not always reflected in practice. Some centres, which stated that they only accepted planned admissions, were found to have admitted children in emergencies without a plan having been agreed. Others, whose stated purpose was to provide care for older children, also admitted younger children. In some cases it was evident that staff found difficulty managing the problems that arose from unplanned admissions.

For a statement of purpose and function to enhance the work of the centre it must be known to the staff members, the admission process must respect the centre's parameters and it must be reviewed regularly to ensure it reflects current need and practices. There were examples of statements that were well constructed but were unknown to the staff, or which were not being used to guide decisions about admission.

2.5 Admissions Policy and Criteria

A centre's admission policy should reflect the statement of purpose and function. Of the twelve centres inspected, ten had a policy or a draft policy on admissions and two had no written policy.

If an admission was planned the standard for admissions policy and procedure was generally met in that social workers supplied social background reports to help residential staff members in getting to know the child, relevant information was provided for the parents and child in advance and they were encouraged to visit the centre before admission. The majority of centres did not, however, supply the child or parents with written information about the centre.

Where a child's placement commenced with an emergency admission inspectors found that, apart from one centre, the drawing up of initial plans for his or her care and education were often delayed. In most cases key workers were assigned to the child at the start of the placement but the appointment of a key worker for the child was sometimes delayed until the manager and social worker were clear about the plans for the child. The lack of available places can contribute to the number of emergency admissions. In at least one board, some emergency admissions of children could have been avoided as the need for a residential placement had already been determined and the children were already on a waiting list. Children identified as requiring residential care, for whom there was no vacancy available at the time, had to remain in unsatisfactory circumstances until the situation further deteriorated. They then had to be admitted on an emergency basis. The centres to which the children were admitted in emergencies were not always in the best position to make the most appropriate response to the particular child's needs. For example, the centre used may have been for a different age group of children or it may have been located too far away from the family home.

Given that most of the centres had children who had been admitted in emergencies, and in some centres the majority of children had been admitted as emergencies, it was surprising that only two centres had written procedures for emergency admissions.

2.6 Care Planning and Review (including involvement of family members)

The inspection process has shown that, overall, care planning for children in residential children's centres is not in accordance with the regulations and was not sufficient to ensure the aims and objectives of the placement were being met. The exceptions to this finding, where good care plans were found, were generally to be found in those centres that displayed good overall standards of care.

The Child Care Regulations (1995) state that before placing a child in a children's residential centre the board shall prepare a plan for the care of the child that, amongst other matters, deals with:

- the aims and objectives of the placement;
- the support to be provided by the health board to the child, the residential centre concerned and, where appropriate, the parents of the child;
- the arrangements for access to the child; and
- the arrangements to review the plan.

Inspectors examined fifty-one case files of children across twelve centres. In forty-one of these files there was a care plan. It is a matter of serious concern that in more than one quarter of cases there was no care plan for the child. Social workers are the designated personnel who should be undertaking this function on behalf of the boards. Care plans were only completed before admission in a minority of cases. Of forty-one care plans examined during the course of the inspections, only 4 were written before admission, 12 were completed on admission and the remaining 25 some time after admission. The time frame for those written after admission varied from a few days or weeks to two years. The regulations state that where it is not practicable to prepare the plan before the child comes to live in the centre, it should be prepared as soon as possible afterwards. In some cases this regulation had clearly been disregarded.

Where it is at all practicable, the social worker, in preparing the plan, is obliged to consult with the manager of the centre, the child and any guardian of the child. The child, the centre manager and the guardian should be shown the completed plan. Many social workers and key workers interviewed about their approach to developing care plans said that in preparing the plan they consulted with professionals and parents. The evidence from the files suggested that practice varied, however, when it came to consulting with the young person or family members. Whilst there was some evidence of the views of professionals being taken into account, it was difficult to find evidence of parents' views or, in particular, a child's views, included in the care plan. There were exceptions to this, but in the main, the written care plans did not reflect the expressed views of families or children. The majority of children did not know of the existence of a care plan.

Care plans are an essential part of the management and planning for a child's placement in care. Where the aims and objectives of a placement are not defined and communicated to the key players it is difficult to see how the potential benefits of the placement can be

maximised. Some social workers have told inspectors that their preoccupying aim has frequently been to find any residential placement for the child; the development of a care plan appears to have been of secondary importance. However, in reviewing practice around the country, the key factors in determining whether meaningful care plans are prepared were found to be the leadership of social work managers and the expectations of managers in children's residential centres.

Of the care plans that were available only a minority were completed to a good standard and seen to be guiding the work being undertaken with the child. The majority of care plans did not meet the standard of the regulations. A wide variation in the type of care plan was found. Approximately two thirds of the care plans examined were written by social workers. The others were written by residential managers or key workers within the centres. There was considerable variation in the contents and quality of care plans. In some instances, a care plan consisted of a few general points about the child and the placement, with no detail of how the plan was to be achieved, what supports were to be put in place or who was to be consulted. One care plan was no more than an account of the placements the child had experienced. It was evident that some workers saw the initial care plan as the introductory and the detailed care plan was not drawn up until the first review took place. In one centre the minutes of the assessment meeting appeared to be used in lieu of a care plan. Some had adapted the 'Looking After Children: Action and Assessment' forms developed in England as a basis for their planning. When utilised, this material generally resulted in well-written care plans. Few of the care plans examined made it clear what the plan was setting out to achieve or set out the aims and objectives of the placement. Seldom did they identify the supports that would be required to help achieve these.

The lack of satisfactory care planning is a matter of great concern that requires to be addressed urgently by health board managers to ensure that the placements of children in care are not allowed to drift. Placements of children in residential care should be planned and purposeful and should not continue for longer than necessary through a lack of attention given to case planning. In order to ensure a greater consistency of approach to care planning the Department of Health and Children should consider developing guidance for boards on the matters which should be addressed by social workers when care plans are being drawn up.

2.7 Review of Care Plans

Inspectors found that in most centres reviews of care plans were held within the time frame required by the regulations. The Child Care Regulations (1995) state that a first review meeting shall be held within the first two months of the child being in the residential centre, and at six monthly intervals for the next two years, and at least annually after two years.

Many children had reviews on a more frequent basis, depending on events and the nature of the centre. In three centres, not all children's reviews were held within the time frame required by the regulations. Responsibility for convening review meetings was shared between social workers and residential managers. The quality of a review meeting was

determined by the quality of the original care plan. It was evident that, in some instances, the care plan review meeting was the place where the care plan was drawn up. Where no care plan had been drawn up the review meetings were inclined to be used to consider the progress of the child rather than whether specific agreed tasks had been carried out to help the child with any particular needs.

The majority of review meetings were helpful in guiding professionals regarding the placement of the child. In the best examples there was evidence that social workers and centre staff had worked closely to ensure children and parents were prepared, included and informed about all stages of the review of the care plan. Where there was evidence of inclusive practice, the views of parents were recorded and where parental views did not coincide with the care plan or where the outcome did not reflect their wishes, clear reasons were recorded on the file. These examples of best practice additionally included named people responsible for executing decisions within a reasonable time frame.

Children in many centres are invited to attend their care plan review meetings, although some centres limit the child's involvement to the last few minutes of the meeting to hear the decisions that have been reached. Children who spoke positively about their meetings had been prepared well by their key worker or social worker, and had a free choice about attending the full meeting. Inspectors found, in some centres, other types of planning meetings taking place where significant decisions were being taken about young people, but in many such meetings they and their families were not involved.

In some centres, there was a general willingness to engage parents and children in care planning, but a lack of awareness of the most appropriate ways to carry out meaningful consultation. While only a minority of case files record whether parents have been invited to reviews, the minutes of care plan review meetings showed that approximately half of parents attended. It seems that there was only one centre where, as a matter of policy, parents were not invited to attend at the review meeting.

Care planning and review are key elements in developing high standards for children in residential care. Adherence to the regulations on care planning and review are crucial in the area of childcare in general, and in residential care in particular. It is not acceptable that many social workers with responsibility for children in residential care do not fully comply with these regulations.

2.8 Young People's Records

The Child Care Regulations (1995) state that 'a health board shall compile a case record of every child placed in residential care by it and the said record shall be kept up to date'. Inspectors examined the case files held within the residential centres, as good practice dictates that all relevant documents should be available to the centre. In children's residential centres legal documents, care plans, medical and school reports and key worker notes tend to be kept on the case file whilst the day to day activities of each child are recorded in individual diaries.

The regulations require that a case file be kept for each child living in a residential centre. Inspectors found that a case file was maintained for every child and these files were kept

in a secure place. However, they found substantial variations in the quality of recording and in the manner in which files were kept. In some centres the files were well organised and maintained to an excellent standard, allowing quick access to essential information. In other centres files were poorly organised, and it was difficult to access relevant information quickly.

In most files some documents that should have been available were missing. For example, only three centres had a copy of the care order or the voluntary agreement for all residents, and only three centres had birth certificates for all the children in their care. Most files contained social background reports and there were a number of centres where social work reports were to be found on all of the files. Only a minority of centres kept full educational notes on file (school reports, meetings with teacher, assessment reports etc). In some case files the information in the medical section was deficient. While the files in most centres demonstrate clearly how medication is dispensed, few centres indicated that the child's medical history had been sought by the child's new GP from the child's family GP in situations where a child had been required to move away from their home area.

The regulations require social work visits to be recorded. These records are usually found in the individual diaries of the children along with a variety of other information, so that access to them is less easy than if they were recorded separately. Inspectors have recommended that social work visits be recorded on a separate sheet, in the individual child's case file, to facilitate monitoring.

Many children and young people expressed an interest in seeing their case files and most of the centres now feel they can show the child their individual daily log. However, only a few centres share the information on the case file with the child (this is usually subject to third party confidentiality and the child's maturity). Staff need guidance and training in dealing with children's requests for access to information from their case files. They may also need more training in keeping case files in a way that will enable the files to be helpful to the child or young person.

2.9 Supervision and Visiting of Young People by Social Workers

Social workers who place children in residential centres are required to visit the children and supervise their placement. The Child Care Act (1991) stipulates that such visits are to be carried out by a person authorised by the board. Social workers are the persons authorised to carry this role in all board areas. Article 24 of the Regulations (1995) require that a child is visited a minimum of every three months for the first two years in the centre and at least once every six months for placements which last longer than two years. This level of visiting does not always reflect the numbers of visits that are usually necessary for a social worker to maintain a meaningful relationship with a young person in care.

Inspectors found that there is an excellent level of visiting of children by social workers. Fifty-five of the fifty-six children in the twelve centres were visited in line with the regulations. Only one child did not have an allocated social worker from a community

care team. Fifty-two of the children were visited in excess of the regulations. The level of visiting did not appear to be influenced by the level of a social worker's caseload or the distances involved. When social workers visit regularly and not only before a care plan review meeting, children were positive about the relationship. All social workers are urged to follow the lead of some of their colleagues who separate the distinct functions of visiting the child and going to meetings.

Frequent visiting usually indicates a good level of supervision but does not guarantee it. Social workers also need to be aware of all policies and practices in the centre, particularly those relating to sanctions, physical restraint and safeguarding issues. All centres completed serious incident reports/significant event forms to record the use of physical restraint, unauthorised absences and other such incidents. However, social workers are only assured of knowing about sanctions or incidents of physical restraint if there is a centre policy of sending social workers an incident sheet describing the event.

2.10 Management

Children's residential centres have a centre manager and an organisational line management system. The excellence of the service on offer in the centre is dependent on the quality of both layers of management and the relationship between them.

Different management structures operated across the centres. Six of the centres had a single manager who worked office hours. Two had a manager and a deputy manager. In one of these centres both worked in the centre while in the other the manager worked from an administrative office away from the centre and the deputy worked in the centre. There were four examples of situations where one manager had responsibility for a number of centres. Two of these managers had a deputy to assist them in their administrative functions. Where managers had responsibility for a number of centres they were based in administrative offices away from the residential centres. The senior house parent in each of the centres was the most senior person available at the centre on a day-to-day basis. The senior house parent in two of the centres worked a shift pattern and this could give rise to problems where staff needed direction and the senior house parent was not on duty.

The line management arrangements for centre managers varied across boards. In the six centres with a single manager, four of the centre managers reported to the head social worker, one to a senior social worker and one to a general manager. The manager and deputy manager of the two other single centres both reported to the child care manager. Where one manager had responsibility for a number of residential centres the reporting relationship was to the general manager.

Within the centre perhaps the single most important role is that of the centre manager. The manager's role in setting standards, leadership and support largely determines how the care staff operate and has a substantial influence on how children experience their placements. Effective centre management was considered by the inspectors to be a very important element in assuring good quality care.

There was wide variation in the degree of confidence, leadership and competence displayed by centre managers in undertaking their task. Some managers had vision, high standards and an effective management style along with sufficient resources to deliver a good quality service. Others struggled without a sense of the purpose and function of the centre or the skills to lead a team effectively. Many of those promoted to managerial positions had been appointed to these posts without having received managerial training. Where this is the case boards should give consideration to enabling such managers to attend appropriate management courses.

The administrative support available to managers is an important element in enabling managers to concentrate on ensuring the quality of care provided for children in the centre. Inspectors found that there were considerable variations in the administrative support available to different centre managers. Managers of single centres appeared to be spending quite an amount of time on routine administrative work, such as going to the local administrative office to get typing done or going to the bank to cash cheques. Inspectors were told of plans for the provision of part time administrative help in some centres, to equip some centres with computers/ word processors and to provide training for key staff in record keeping. If the plans materialise they should result in service improvement. Inspectors noted there were substantial differences in the budgets allocated for different centres, with the result that some managers were able to offer a better standard of living to the children in their centres than those with lesser budgets.

In some instances residential managers were invited by head social workers to join the social work team at team leader level for managerial input and support. In others managers worked alone, with limited supervision and guidance. Inspectors were concerned at the relative isolation of many centre managers and staff teams, particularly in the case of single managers with responsibility for one centre. In many boards, children's residential centres are currently expected to serve all the residential child care needs of a specific community care area. Although this model has some advantages, in practice, the manager and staff team are often not particularly well integrated with the local social work team, and the structure lessens the prospects of the centre working with other residential centres and sharing ideas about best practice.

Traditionally health boards have not been the direct providers of residential child care. Organisations with a tradition of providing residential child care are often able to offer managers effective guidance based on experience and provide them with developed policy as well as procedural support. Managers in several boards sought from inspectors advice on policy, procedures and practice across a wide range of issues including the development of statements of purpose and function, sanctions policy, complaints procedures, access to information and training for staff members. Few senior managers in the boards had direct experience of managing residential child care. There would be merit in boards arranging orientation training for those managers who have not previously had much experience of residential child care

Line managers recognise the complexity of the tasks involved in residential child care. However, each board is confronting the continuous change that now characterises the field. Several boards had established working parties to review the key issues facing residential child care in their area with a view to determining policy for the future.

Inspectors suggest that to manage this successfully, boards will need to adapt a style of management that is capable of both planning for change and motivating staff in residential centres to respond to these changes.

In the main, centre managers who had clear lines of accountability, carried out regular monitoring and evaluation of care practices and sought to make clear to parents, children and other professionals the objectives of their centres, provided good standards of care to their residents and developed good partnership relationships with parents.

2.11 Role of Health Boards in Monitoring of the Implementation of Regulations and Standards.

Regulation 17 of the Regulations (1995) requires a health board to monitor implementation of the standards set down by the regulations to ensure compliance. It requires the board to ensure that arrangements are in place for an authorised person to visit the centre from time to time to satisfy it that the centre is complying with articles 5 to 16 of the regulations. These regulations relate to such matters as:

- care practices and operational policies;
- staffing;
- accommodation;
- access arrangements;
- health care;
- religion;
- provision of food and cooking facilities;
- fire precautions;
- safety precautions;
- insurance;
- notification of significant events; and
- records.

Of the 12 centres inspected, only four said they had a designated authorised person monitoring the standards. Two centres said the childcare manager acted in this role, but, in one of the centres, there was no record of visits or reports available. In two centres the inspectors of voluntary children's residential centres were said to be the authorised person. There did not appear to be anyone designated to undertake the monitoring function for eight of the centres. In the boards where board inspectors were undertaking the function there were comprehensive reports on how the standards were being observed. This met the requirements of regulation 17.

Inspection provides a snapshot of a centre at the time of the inspection but it is not a substitute for regular monitoring that provides managers with a continuous picture of how the centre is operating. Without monitoring by a designated authorised person it is doubtful if a board can adequately satisfy itself about the standard of care being provided in its centres. The observance of regulation 17 is crucial in ensuring that centres are complying with the regulations and a good standard of care is being provided for the children who are resident. The person appointed as the authorised person should have independence, seniority, a good knowledge of residential child care and an understanding of the Child Care Regulations.

3 Inspection of Care Standards

3.1 Psychological and Emotional Development

Many of the children living in children's residential centres have experienced profound loss, and many have also experienced abuse and neglect. In the face of such adversity, children respond in many different ways. Some appear to be more resilient than others, and some are reluctant to invest in meaningful relationships with social workers or staff members.

The task for child care workers is complex. Managers need to make certain that children experience their care as safe in all respects, and they need to be able to reassure the children that the staff have the capacity to understand, accept and cope with the multifaceted and sometimes contradictory feelings they may experience. At the same time, the child care worker must support the child with the normal developmental stages, and help him or her find ways of managing unacceptable behaviour. Although the key worker has a crucial role in ensuring a child's emotional needs are met, all staff members, in the course of everyday life in the centre, should be aware and responsive to his or her emotional needs. Social workers should ensure that plans are in place to address the problems resulting from the traumas experienced by a child before coming into care and that active steps are taken to implement these. It is imperative that the emotional and behavioural difficulties that children may display are addressed early and thoroughly. Residential child care staff should expect some of the children admitted to children's centres to present difficult behaviour and to see this as a normal aspect of their work.

It was reassuring to find that in the majority of centres, staff were empathetic to the experiences of the children in their care. All the children had a nominated key worker who would take a special interest in their progress. The task of the key worker, however, differed across centres. In some the key worker attended to the administrative and practical work associated with the role. In other centres, the key worker additionally devoted time, energy and skill to the emotional welfare and psychological development of the child or young person. Centres where the roster had dedicated 'key working time' were more likely to have key workers engaging with the emotional world of the child. However, only a minority of staff displayed confidence in working directly with those children who presented severe emotional and psychological problems. Often in cases where it would have been appropriate the care plan did not focus upon or address the emotional and psychological difficulties of the child. Many staff clearly needed additional training and support to help them develop their competence in this area, adding emphasis to the suggestion that some attention may need to be given to revision of the content of existing child care courses.

Children who have experienced many upheavals in their lives need a secure and safe environment. This requires a settled staff group. The retention of a good group of core staff in a centre is important. Staffing problems are referred to in another part of this report, in particular, the high turnover of staff members in some centres which does little to encourage an environment in which trust, continuity and confidence can develop.

All centres were able to refer children for child counselling, when appropriate. This was usually available through child psychiatric services. Centres reported that children benefited from such a service. Where guidance was offered by child psychiatry to the child care staff regarding the management of a child this was usually found to be helpful in their day to day work. There were, however, difficulties associated with these referrals on occasions. In some boards there are long waiting lists with the result that access to child psychiatry is not always available when it is needed. Children over 16 years are regarded as being over the age for which child psychiatry services are available and have to be referred to adult psychiatry. Not all young people who require specialist assessment or counselling services are willing to attend.

While there is no substitute for the appointment of a well qualified staff group unqualified staff members can be helped to improve their care practices by the provision of in service training, support and ongoing supervision. The use of an outside consultant to a centre, with a focus on specific and general issues displayed by the children in the centre can be a useful support.

3.2 Health Care

Across all of the centres, young people were found to be in good health. In general, young people attend the centre's GP. One centre had great difficulty in finding a local GP to accept a new resident on to their medical card lists. In a number of centres some of the girls said they would prefer to be registered with a female GP, but this was not always facilitated. A minority of centres required children to be medically examined on coming into care, although all centres would arrange one if there was any cause for concern. Although, as mentioned in the previous section, young people can be referred to child psychiatric services, staff in several centres complained of delays in accessing these services because of the long waiting lists. The most common delays in receiving specialist services were reported as being for psychological and psychiatric services.

The food that is served in centres is usually of good quality and nutritious. Staff members with imagination and culinary skills provide an important service in creating a caring and nurturing atmosphere. In these centres, the kitchen became a natural place for staff and young people to chat, laugh and spend time together. There were occasional exceptions where an over reliance on frozen/instant food was evident, or where the food, although nutritious, was lacking in variety and choice.

In the area of health care there were two issues that caused concern in the majority of the centres. These were smoking and education on sexual development. An area of serious concern was the level of smoking by children and young people in children's residential centres. Only three centres had a policy of no smoking. There were a variety of policies and practices regarding smoking in the other centres. In some, young people could smoke if their parent gave permission. In some others young people over 16 years were allowed smoke. While in most centres there was a no smoking rule, smoking was often permitted outside the centre. Young people in one centre were permitted to smoke a limited number of cigarettes if the parents gave the cigarettes to them. In one centre young children were allowed smoke in the centre.

The issue of children smoking is a complex one as many of the young people have acquired a smoking habit before coming into care, and some of the older residents argue that smoking is a normal and legal, if unfortunate, habit in their peer group. There are difficulties managing a no smoking policy where young people are admitted to centres in an emergency situation or where young people over the age of 16 are in secure care. Inspectors consider, however, that greater efforts need to be made to ensure that children in care are made fully aware of the hazards of smoking and are encouraged and helped to give it up. Boards should give centres clear guidance on what is permissible and staff should be given support and training to implement new rulings. In one centre, staff gave children cigarettes that had been provided by their parents. It is not acceptable that young people in care are given cigarettes by staff members and knowingly allowed to smoke. Where staff know that a young person is a smoker they should ensure that the young person is offered the opportunity to participate in a helpful anti-smoking programme. All centres should be able to show that they are actively encouraging young people who smoke to give up the habit.

Matters of sex education were dealt with in a patchy way and whether this was dealt with at all was often dependent upon either young people seeking advice or individual staff taking the initiative. The policy in a minority of centres required key workers to pay attention to this matter. Several centres had ad hoc arrangements whereby a key worker would address the subject with the young people, but there were few checks and balances in place to ensure this occurred. Some staff members said they felt ill equipped to discuss this area, particularly in situations where a young person had experienced abuse in their past. Centres need to ensure that all areas of health education are given proper attention. There were few good examples of staff helping young people deal with the issue of sexual education in the context of personal relationships. For the most part the needs of young people to have appropriate sex education are not being met.

Medication was kept safely in all centres, although in several instances inspectors recommended that recording of the administration of medication be improved.

3.3 Unauthorised Absences

Six of the centres produced written policies outlining how staff should deal with unauthorised absences of young people. Consistently, these policies provided guidance as to whom staff should provide notification and how incidents should be recorded.

In four of the centres inspected to date unauthorised absences featured prominently and had, on occasions, reached unacceptable levels. Six other centres were able to report that they experienced few, if any, incidents of young people going missing from care. A small number of centres had considerable problems with unauthorised absences whilst it had not been a significant issue for many of the other centres. Analysis of unauthorised absences suggested that, for the most part, persistent absenteeism involved a relatively small number of young people.

Inspectors found that unauthorised absences were being recorded and discussed at review meetings. It is clear that unauthorised absence is a matter of concern for professionals

concerned with residential child care as they realise children who absent themselves without permission may well be placing themselves at risk.

The recording of unauthorised absences and incidents were written up in a variety of different recording systems. They are normally recorded on either 'significant incident' sheets or on 'serious occurrence' forms. Because these forms are also used to record a range of other incidents it was difficult for inspectors to separate out unauthorised absences from the other incidents to enable quantification the actual number of absences that had taken place. Likewise the monitoring of unauthorised absences by managers would not be facilitated and inspectors have suggested that separate records of these are maintained in a way that will in future facilitate such monitoring.

Centres were not consistent in notifying parents when young people had gone missing.

3.4 Access to Information

Young people were generally unaware of their rights of access to information kept about them on their case files and there was little evidence of social workers or centre staff promoting such awareness. Examples of young people seeing their files usually coincided with their having made a request. In the course of inspections young people revealed to inspectors a keen interest in seeing the information that residential care staff and social workers had written about them. Often, the information to which young people were given access was limited and depended upon whom they asked. This sometimes resulted in practice that was arbitrary and inconsistent.

There was little evidence of staff having received training in how they can most effectively deal with young people's requests for access to information kept in their files, or on the requirements of the freedom of information legislation. Neither was there much evidence of staff receiving training on record keeping or on report writing.

One centre had a policy on young people's access to information and had included information about access to information in the young people's booklet. However, there was no written policy on this in most centres, and there was little guidance provided for staff on how requests for access to information on personal files should be handled. Even where a board had written policies about access under the freedom of information legislation these had not been sufficiently implemented at a local level.

Residential care staff generally showed limited awareness of the requirements of freedom of information legislation and were largely unaware of the obligations within the United Nations Convention on the Rights of the Child (1989).

A few centres had developed, or were developing, an information brochure to make available to parents and children. These were intended to provide factual information, about the centre and how children can expect to be treated while in residential care. Where provided, children and their parents regarded them as helpful. The information brochures did not usually include information about the rights of children, although one

centre provided an example of what can be achieved. In some of the other centres few of the parents and children had been provided a clear understanding of what exactly the centre did or how it aimed to carry out its task.

3.5 Child Protection

Young people generally confirmed that they felt safe living in children's residential centres and would tell someone if they did not. The evidence gained from reading records of unauthorised absences suggested that some young people place themselves at risk by running away. In centres where absence levels were highest the children could be considered to be more at risk than in centres with low levels of unauthorised absences.

Child protection policy statements and guidelines informed practice within six of the centres. There was an absence of guidelines for staff in the other centres. However, in all centres, staff knew who they should inform if they had any child protection concerns. Only two centres to date had implemented anti-bullying policies.

Most of the residential care staff, social workers and managers interviewed were aware of the existence of 'Children First' guidelines, but many revealed that they had still to acquire a working knowledge of all of its contents and requirements. There was a rudimentary awareness of child protection procedures, often limited to an understanding of the person to whom concerns are to be notified. This round of inspections indicated the need for more training in child protection for residential staff.

While inspectors found that some children who had been abused before admission to care were being referred to specialist units for help there was little evidence that young people's past experience of abuse was being addressed directly with them by staff within the centres. In some cases this may have been related to a lack of staff competence in dealing with such matters. Staff working in the centres, however, generally showed good awareness of and contributed towards safe care practices in the centres.

3.6 Complaints Procedures

Half of the centres had written complaints procedures in place. One was developing a complaints procedure and another centre referred inspectors to the board's procedure. The procedures generally lacked clarity about how different types of complaint should be investigated, who should investigate or carry out other required tasks and the timescale for completion of investigations. In practice, most operate as notification procedures. Action tended to result only when a manager of sufficient seniority decided how it should be handled. Most complaints where abuse has been alleged are automatically referred for action under the child protection procedures. Procedures set out requirements for making and retaining a written record of complaints.

The majority of formal complaints reviewed related to allegations of abuse by staff and other young people. There was little indication of complaints procedures dealing with other less serious concerns or dissatisfactions that young people may have.

Many local arrangements for handling complaints were found to be incongruous with board procedures, of which a number of centres were unaware. Even where a designated complaints manager for the area had been nominated under these procedures some centres were not fully familiar with the development and staff appeared unaware of the name of the designated manager. Inspectors found significant variations in how staff under investigation were treated, even within the same health board. Not all were suspended and amongst those who were suspended pending investigation some continued to receive full pay whereas others were suspended without pay.

In some centres young people and their families were given written information, which included an explanation of their right to complain. However, it seldom gave any account of how their complaints would be handled. Occasionally care staff made the presumption that young people would know how to complain but had not checked this out with the young people themselves.

Many young people regarded complaints procedures as fair. Whilst this was encouraging, inspectors noted that very few complaints had been reported in some centres. They also noted that only a small proportion actually found in the young person's favour. Further, aside from those complaints that subsequently involved the Gardai, none were subject to independent consideration and boards often stood as having been judge in their own cause. The inspectorate has recommended that all complaints procedures should make provision for independent scrutiny of complaints when they reach a certain stage.

Inspectors found some evidence, in one centre, of young people being encouraged by care staff to use their right to complain, but this was mainly in regard to complaints they had about other residents. Attitudes towards complaints against staff sometimes provoked a defensive reaction.

There has been no attention given to supporting young people through the services of advocacy. It has been suggested to inspectors that this was a role that could be provided by social workers. While the acceptance of such a role by social workers would give some degree of independence from the centre it is not likely that it would adequately satisfy young people's need for their case to be assessed by someone who is completely independent and can provide totally impartial support.

Care staff and managers have received little or no training in how to handle or investigate complaints.

3.7 Consultation

The Regulations require that in preparing the care plan a board shall consult the manager and, in so far as practicable, the child and anyone who in law is a guardian of the child. Young people generally related to inspectors that they were consulted by staff regarding decisions affecting their daily lives and felt that their views had been taken into account.

Nine of the centres hold, or have until recently held, regularly weekly meetings for the young people. Centres have been commended on this practice, but inspectors have also

suggested ways in which they could be made more effective in giving young people a voice.

There are no written policies or guidelines in any board that set out how the views of young people are to be sought. Consequently, while in some centres it was clear that staff took care to ensure that the young people were actively involved in their own case reviews, the degree of their involvement in other centres was minimal. In some centres decisions were taken about the future of the young people without them having been included in consideration of the matter.

Consultation was restricted and young people's views were often confined to narrow issues concerned with their own care. There was limited evidence of young people being asked for their views on how well a centre runs or does its work. There were no examples produced of young people being consulted about the future development of care services.

3.8 Leaving Care

Inspectors found examples of staff from some centres providing aftercare support for young people on an outreach basis. Often this role was not formally recognised by the Boards and this essential task was largely being maintained in some parts on the basis of staff goodwill.

Inspectors saw few examples of young people taking part in independent living programmes, although those that were in existence were impressive. In the main these programmes concentrated upon developing young people's experience of handling money, acquiring domestic skills, using public transport and employment. These were often predicated upon staff initiative as distinct from conforming to any policy or practice guidance on preparing young people for leaving care. Of all the centres only one had a written policy relating to the preparation of young people for leaving care. Three centres had access to a dedicated aftercare service.

Rarely was there evidence of a clear and costed programme in place for the support of young people leaving care. Generally, planning for young people leaving care is being left late and in some cases it not happening at all. Too often young people are leaving care in an unplanned way, and this is not conducive to promoting their welfare.

In two centres there was a nominated worker who had been assigned responsibility for supporting young people leaving care.

3.9 Living Skills

In most centres there was a range of activities for young people offering a diverse choice. Activities were adequately funded and tended to reflect young people's own interests and individual talents. However, much of young people's recreation focused upon outside activities and in-house activities in most centres appeared limited and unimaginative, by comparison. In spite of this inspectors found, with a few exceptions, that television plays only a cursory part in the lives of young people in care.

Inspections showed significant discrepancies in age-appropriate care and notable variations in young people being allowed out unsupervised, pocket money rates and bedtimes. There were also interesting differences in choice of holiday destinations with some young people jetting off to some exotic locations as against others who have had to settle for something a little more modest.

There were opportunities in all of the centres for young people to participate in the weekly shopping, or buying clothes. This was limited in some centres by the fact that shopping tended to occur whilst young people were at school or work and on occasions by insufficient availability of staff on shift. Past experiences sometimes had a bearing on the decision to restrict outings to the shops where young people have been embarrassed. Inspectors found many examples of purchases being made through an order book, a method of payment that is prone to identifying young people as being in the care of a health board.

Many of the centres had their own transport or had placed requests for transport to be provided that were still being considered.

3.10 Use of Physical Restraint

Of the centres inspected to date six had adopted a formal written policy on the use of physical restraint, whereas the other centres had not. Each of the centres which had policies in place cited therapeutic crisis intervention as the only permitted method.

There was evidence that most staff had received training in therapeutic crisis intervention, even in those centres that did not have a policy on the use of physical restraint. Inspectors consistently found centres in which over three quarters of the staff group had participated in a relevant course of in-service training, typically lasting four days. In some instances the evidence was that this was the sole content of training provided to staff working in children's residential centres.

There were relatively few examples of centres being over-reliant on the use of physical restraint and many revealed considerable skills in being able to diffuse potentially volatile situations. In the main centres did not to use it and some had policies emphasising it as an intervention of last resort.

One centre relied excessively on the use of physical restraint. This was in contrast to the practice in some other centres where no, or very few, young people had been physically restrained at all. In a few centres restraint was used periodically. The use of physical restraints could not be explained solely through an analysis of any challenging behaviours that young people were presenting. Although some young people's behaviour was noticeably more difficult than others inspectors do not think that this adequately explains the discrepancies that were found in centres reliance upon the use of physical restraint. Inspectors also noted that those centres which relied upon it the least tended to be better at applying physical restraint in line with required policy.

Incidents involving the use of physical restraint are generally recorded. However, only one centre had developed a recording system specifically in respect of its use of physical

restraints while other centres recorded the use of physical restraint on general significant incident sheets.

3.11 Sanctions Policy

Seven of the centres had a written policy in place on the use of sanctions. Inspectors found that the sanctions imposed were generally fair, reasonable and proportionate to the behaviour that staff were trying to correct. The better examples emphasised measures intended to help the young person and reduce the likelihood of negative behaviour reoccurring.

There were exceptions whereby inspectors concluded that the sanctions that had been applied were unacceptable. Examples included an excessive period of grounding and excluding young people from having any contact with peers or staff as a punishment. Young people had sometimes been excluded from, or locked out, of the centre for a period as a staff response to their behaviour. Inspectors question where this practice leaves child care professionals in regard to their wider duty of care.

In those centres that had a sanctions policy staff were aware of it and tended to apply this in practice. Not surprisingly, those centres that did not have a policy or where it was not sufficiently understood found that staff were applying sanctions inconsistently.

Inspectors found that details of sanctions were being recorded by staff, but not usually in a separate book.

The use of sanctions was not being monitored or reviewed to appraise their effectiveness. Inspectors found some examples of sanctions being repeatedly applied where evidence clearly indicated that these were not having the desired effect nor were they likely to.

3.12 Working in Partnership

Inspectors found many examples a good working partnerships between residential care staff and other professionals that their work brings them into contact with. Positive professional relationships were evident by the frequency of meetings, and other contact being maintained, between residential care staff and social workers.

There were occasional difficulties between residential care staff and social workers but these were generally confined to aspects of defining roles and responsibilities in relation to day-to-day tasks. Such difficulties were most evident in those centres that had experienced a number of recent changes of centre manager. Also, many residential care staff and social workers observed that communication was an area that could be improved, and there were occasions where information could have been communicated at an earlier stage or in greater depth.

Centres generally had good relations with neighbours, although some centres had experienced tensions with members of the local community, sometimes related to the behaviour of the children.

Some centres displayed a strong commitment to working with families of the children and showed innovation in seeking to achieve this. Other centres still have much to improve upon in this area.

Reference was made earlier to the difficulties children's residential centres experienced in accessing specialist assessment and treatment services for young people. This is a problem that needs to be addressed by the boards if the quality of services for children and young people in their care is to be improved.

3.13 Education

Each young person in residential care has a right to education. The care setting should be one in which education is valued, children's educational needs are actively addressed, and each young person is encouraged to attain his/her potential. Attendance at school can offer opportunities for improving self-esteem and can afford a normative experience for children living in different circumstances to their peers. It can also provide young people from socio-economically disadvantaged backgrounds a gateway to opportunities in adulthood.

Of the fifty-six young people surveyed in the residential care centres, thirty-seven (66%) are of school going age. Twenty-eight (75%) of these young people were attending either primary or post primary school, three of whom were attending special schools for young people with learning difficulties. One young person was attending an alternative school programme.

In general staff were attentive to the educational needs of the young people in their care. Young people usually had a quiet place in which to do their homework and were provided with assistance where necessary. Young people stated that they were supported in the different aspects of their school life: books, uniforms, parent-teacher meetings and school outings. In a few cases staff members accompanied young people to school as a means of sustaining their school attendance.

Responses to the inspectors from schools, although limited, were generally positive. Teachers commented on the fact that the young people received support and encouragement from the centres in relation to their educational needs. In some instances, however, schools requested more information from, and contact with, the residential care staff. Those centres that had regular liaison with schools and daily routines in relation to homework were the ones most likely to assist young people in maintaining their progress and in sustaining school attendance.

Eight (23%) of the young people were not attending school at the time of the inspection. Three of these were registered in schools, but were refusing to attend. One centre was attempting to persuade the young person to return to school, outlining a future training option that would be available if the young person continued in school for the remainder of the year. Another centre had no constructive plans for how the young people were to occupy their time or who was going to supervise them.

Five young people had no school placements. The decision regarding a school placement for one young person, who was admitted on an emergency basis, was pending a planning meeting regarding his placement. Three young people had histories of behaviour problems in school and on this basis applications to schools were refused. A fifth young person had learning difficulties and a referral to a school appropriate to his needs was unsuccessful due to lack of resources in the school. A request for additional resources to accommodate this young person had been requested of the Dept. Education and Science, but at the date of the inspection, there was no reply to this request. Ironically this young person had been attending a special class in a school in his local area before moving to his placement in residential care.

In response to the lack of school placements, two of the young people had received home tuition for approximately ten hours per week. A third young person attended a programme run by the home youth liaison service for a minimum of ten hours per week to receive tuition for his Junior Certificate examination.

Of the remaining 19 (34%) young people between the ages of 16-18 years, 8 attended post primary school; 4 attended FAS youthreach programmes; 2 participated in a training programme run by the local youth service; 1 was employed and 1 attended a special needs service. Three were unoccupied during the day.

Less than half (41%) of the young people between 16-18 were in 2nd level education. These eight young people spoke of being encouraged to sit state exams, they were aware that extra tuition would be provided if it was required, and some talked of plans for 3rd level education.

Higher educational expectations for young people in residential care are needed if they are to achieve their educational potential. Home tuition is not a substitute for mainstream schooling. Attention should be paid to those young people who have a history of school refusal, special educational needs, and those whose difficult life experiences have contributed to behaviour leading to suspensions from school. No young person should be educationally disadvantaged as a result of moving to residential care.

3.14 Respect for the Privacy, Dignity and Individuality of Young People

Young people reported that their privacy was respected and that information contained about them was confidentially maintained. Staff generally showed respect for the children's privacy by knocking on bedroom doors before entering, allowing children to bath in privacy and allowing them to open their own mail and send letters and make telephone calls to family and friends, within reason. In general, young people were also given opportunities to be alone or undisturbed when this seemed appropriate. However, in a few instances the physical layout of the centres made it difficult for children to have privacy for visits from their families, particularly where there was only one sitting room that doubled as the children's sitting room and the room for such visits. In two centres it was necessary for adolescents to share a bedroom with a younger child because of the limited number of bedrooms. This was generally regarded as unsatisfactory. However, in the majority of centres the young people had their own attractively decorated bedrooms,

in which they were permitted to display their own posters and photographs, reflecting their personal interests. Most of them had a strong sense of ownership of their rooms.

Inspectors noted many positive examples of staff providing individual care, within the context of group living. Staff made themselves aware of the young people's likes and dislikes and made efforts to accommodate these as far as practicable. They also encouraged the development of individual talents and young people were encouraged and facilitated to follow their recreational interests and hobbies such as horse riding, swimming and involvement in youth clubs. Individual achievements were celebrated.

Young people were conscious of the fact that they lived in a children's centre and many were very sensitive regarding any practice that might identify their care status. In some centres the methods used to purchase items such as food or clothing were a source of embarrassment to the young people, since they clearly identified the purchases as being for children in care. Where appropriate, recommendations have been made by the inspectors about changing the methods of purchasing used by some centres when the young people are present. In a small number of centres the use of group transporting vehicles caused some embarrassment to the young people by making them appear different from their peers in the community. Staff were sensitive to these concerns and when centre vehicles come up for replacement more acceptable vehicles need to be acquired.

3.15 Preserving the Young Person's Sense of Identity

Residential care staff in general recognised the importance of family as a source of the young person's identity and placed a strong emphasis on family involvement. The majority of parents interviewed stated that they were always welcome in the centre and were treated with respect by staff members. There were many examples of staff facilitating transport arrangements for family visits.

Staff had relevant knowledge of young peoples' backgrounds. There was evidence on case files of detailed social histories ensuring key workers were familiar with the divergent backgrounds of the young people.

A number of young people had previous foster care placements, the breakdown of some of which led to their residential care placement. Although the circumstances of such breakdowns can be difficult, young people were facilitated in maintaining contact with significant foster carers.

In some instances however, staff members were unclear whether it was the role of the social worker or the key worker to facilitate the young person in developing a clear knowledge of their family background and the reason for their care placement. This is a significant issue that should be identified and addressed as part of each young person's care plan.

In the main, school reports, photographs and other memorabilia were preserved both on young people's case files and displayed around the house. Staff members acknowledged achievements openly and framed photographs of special occasions were also evident.

Unfortunately, this standard was not adequately met in respect of two centres. In one centre there was little sense that families featured strongly as a source of identity for the young people. By contrast, the young people had a distinct sense of their status and identity of being in care. In the other centre the young people did not present a positive image of themselves and their identities were dominated by definitions attached to their presenting problems and care status. Inspectors accepted that there can be particular reasons why some of the young people's families do not feature strongly in their lives but urged that management and staff are careful to ensure that their care status is not negatively reinforced.

3.16 Maintenance of a Register

Under Article 21, Part 1V of the Child Care (Placement of Children in Residential Care) Regulations 1995, the health board should maintain information on individual young people who are admitted to the centre. There was no register kept in respect of four of the residential centres. In some instances the names and addresses of the young people's parents were not included in the register.

3.17 Insurance

Health boards must ensure that all children's residential centres are adequately insured against accidents or injury to young people placed in the centres. This standard was met in respect of the majority of the centres and evidence of adequate insurance cover and policy details were made available. In one of the centres the standard was unmet, as the inspectors saw no documentation in relation to insurance cover.

3.18 Safety

Seven of the centres had a health and safety statement and six centres had designated a specific staff member as the health and safety officer.

In general, staff members had an awareness of safety issues. Medicines and cleaning materials were stored safely and there were procedures in place for reporting any accidents or injuries to young people or staff. However, while some staff had received training in first aid, there was an overall deficit among the staff groups in relation to training in health and safety.

Children's residential centres need to be able to maintain a level of safety and a standard of care comparable to any family home in the community. Dissatisfaction was expressed by some centre managers about long delays in accessing boards' maintenance services.

It is the responsibility of each board to satisfy itself, by undertaking a proper risk assessment, that its centres provide safe environments for young people and staff. A health and safety audit had been completed by the health and safety officer in six out of the centres. Generally, urgent repairs where safety was involved were attended to promptly in most centres. However, at the time of the inspection there were also outstanding corrective measures identified by the audits, in several of the centres, that had not yet received attention. In some cases the delays were up to 11 months.

3.19 Fire Precautions

Eight out of ten centres had certificates of inspection/service records in relation to automatic fire alarm systems and nine had evidence of maintenance checks of fire extinguishers.

The most uniform deficit in relation to fire safety concerned the unacceptable lack of fire drills. No fire drills had taken place in three of the centres over the previous two years. Four centres had only one record of a fire drill, all of which took place very shortly before the inspection. One centre informed the inspectors that a fire drill had taken place in the previous year but this was not recorded. One centre had a record of regular fire drills but none of the young people had been involved. Only one centre met the standard in relation to fire drills.

Where fire drills did take place they were inadequately recorded. The records did not include the number of staff and young people involved in the drill, the time the drill took place, the length of time it took to evacuate the premises and any difficulties encountered.

Staff training in fire safety was also inadequate. Only four centres received training in respect of fire safety and evacuation procedures.

3.20 Pets

While most of the centres stated that they would be open to keeping pets, only two of the centres inspected actually kept a pet. Some of the centres had kept pets in the past but these had not been replaced. One centre gave an example of a young child, admitted in an emergency who was allowed to bring her pet hamster with her.

The keeping of pets in a residential centre can contribute towards promoting the welfare of young people and help instil a sense of responsibility. It can also provide a measure of consistency in the life of a young person. It is hoped that where possible the residential centres will accommodate the keeping of pets.

3.21 Administrative Records

In general centres kept clear and concise administrative records which were legible and up-to-date.

A number of administrative records were common to all centres:

Communications Book/Daily Dairy

Communications books were kept to record details of appointments, visits to the centre and internal messages regarding reviews, case conferences and other relevant information. Recommendations were made that the names of the young people in the centre and the staff members on duty were also recorded in this book. It was also recommended that a discrete record of social worker visits to the centre be kept, as this was not done in all cases.

Daily Log Books

Daily log books were kept for each young person. These logs recorded a commentary the young person's general well being, visits received, sanctions imposed and other relevant information. Although with some exceptions, log books were kept clear and concise, were legible, dated and signed.

Sanctions Book

Not all centres recorded the application of sanctions in a separate sanctions book, although sanctions were recorded in the individual log books. In some instances there was not sufficient information recorded in relation to the reason for the sanction being imposed. As pointed out by the inspectors, a sanctions book should contain sufficient information to enable managers carrying out their monitoring function to check that policy and procedures which inform the use of sanctions are being complied with.

Incident Sheets

All centres use incident sheets or serious occurrence forms to record serious incidents such as unauthorised absences, dangerous behaviour or accidents. These are forwarded to the residential care manager, relevant social work personnel and copied to the young person's file. Some of the incident sheets used by the centres lacked provision for any comment by the centre manager following a review of the incident. Also, in most instances the serious occurrence forms did not record whether parents were informed of the incident and the date this took place.

It is important that incident sheets are devised to record all relevant information so that they assist the manager and staff to review serious incidents and analyse causation factors, triggering events, patterns of behaviour and the impact of subsequent actions. It is imperative that serious incidents do not get lost in the daily life of residential care, but are reviewed rigorously to provide guidelines to managers and staff in responding to the individual needs of young people.

Medical Book

All centres kept records of medication given to young people. However there was a lack of clarity in some centres as to whether it was a practice to record non-prescribed medication. Where some young people were in receipt of medication for long periods of time, inspectors noted that there was no record in the medical book to show who authorised any change in medication and the date this took place.

4 Conclusions and recommendations

4.1 Overview

Inspectors found that, overall, senior managers and local centre managers were welcoming of the inspection process. All those involved said it helped focus on issues of quality and client participation. While there is evidence that most of the centres inspected have begun to address the standards it is clear that many still have a long way to go. There is, however, some comfort in that, we found in all of the centres inspected, many committed and caring staff who have earned the respect of the children and young people with whom they work. If the conclusions of this report focus on the matters that need to be addressed it is not to say that we did not find much good quality of work being done with children and a sound basis for the development of a good standard residential care service. The main concerns relate to the recruitment and retention of staff, the training of staff, care planning and review, management and monitoring of residential care services and the support arrangements for children in residential care.

4.2 Management and Staff Training

Referring social workers and line managers frequently acknowledged there was need for improvement in child care training. The Expert Group on Various Health Professions has recommended “*that child care workers be accorded formal professional status and as a consequence recruitment of non-qualified personnel must eventually cease*”. In pursuance of this it has recommended that a joint committee be established to deal with the issues arising from recognition of the autonomy of the child care profession including “*a complete review of the training available to child care workers, with a view to the introduction of a nationally recognised professional qualification and the provision of in service training*”. SSI supports this recommendation. There needs to be a substantial increase in the number of qualified staff recruited for residential child care work. Where it is not possible to attract qualified staff consideration may need to be given to the development of trainee schemes and the secondment to professional training courses of unqualified staff who demonstrate potential and commitment.

It is also a matter of concern that some centres are being run by staff with very limited experience of residential child care. Recruitment arrangements do not always work in a way which facilitates the most efficient recruitment of staff and delays in getting vacant posts filled has been a problem, leading to the employment of many staff on a temporary basis. While there are exceptions to be found, staff without a permanent contract are less likely to be committed to the provision of dedicated care than those who occupy care posts on a permanent basis. The consequent turnover of staff resulting from recruitment of so many staff on temporary contracts contributes, in some centres, to a lack continuity of care for the children.

4.3 Agreed Standards

There are a number of areas where concerted action by the Department of Health and Children and the health the boards is necessary if early progress is to be achieved in

raising the standards of residential child care services. The development of a set of standards by the Department in agreement with health board representatives has been an important first step. In order to ensure that the standards required of the voluntary sector are consistent with those the Department have established for the board run centres, it is recommended the Department should now establish a set of national standards for residential child care, which would cover both voluntary and statutory sector centres. Consideration should also be given to the possibility of applying these standards to other institutions where children are cared for in out of home residential settings, such as those referred to in the Introduction section of this report.

4.4 Care Planning

The inspections have revealed that the requirements of Article 23 of the Child Care Regulations 1995 are not being consistently met by social workers. The regulations require a health board, before placing a child in a residential centre or as soon as practicable thereafter, to prepare a plan for the care of the child. Inspectors found that too often this requirement was not being seriously addressed. Attention requires to be given to the need for improvements in care planning. The inspections to date have shown that care planning is weak, and sometimes ignored. This is a most unsatisfactory situation. It can lead to children being allowed to drift in care when good planning would have identified the matters requiring to be addressed and directed services towards those matters, thereby enabling more children to be able to return to their homes or move on with confidence to living independently. It is to the credit of residential centres that some residential child care staff have drawn up residential plans to guide their work, but these should be placed in the context of the overall care plan which is the responsibility of the referring social worker. Without, proper care plans which set out the aims and objectives of the residential placement and the support to be provided the child, the centre and where appropriate the parents, the reviews of the cases of children in residential care are less meaningful. Planning and review must be addressed more seriously in future.

4.5 Local Monitoring

A further matter of concern is the lack of attention given by the boards to monitoring of placements. The responsibility for monitoring of standards is clearly placed upon the health boards by Article 17 of the Child Care regulations 1995. Various records are required to be maintained to facilitate this activity but in many cases inspectors discovered that no authorised person had been appointed by the board to undertake the monitoring function. Consequently, managers relied on the accounts of residential managers regarding the standards of care being provided in centres. Normally, the line manager for the centre would be best placed to carry out this function but it can be delegated to someone else who can in turn report the findings of monitoring exercises to the line manager. In some cases line managers were surprised to learn of the findings of the inspectors. Had they carried out their role regularly they would have had a better idea about how the services were being provided. The board is left in a vulnerable position if it does not ensure that monitoring of standards is carried out regularly. Whilst inspection will provide relevant information for those with responsibility for monitoring it can only take place periodically. Monitoring needs to take place on a regular basis and result in a

report to those responsible for management so that any weaknesses can be addressed promptly.

4.6 Support and Supervision

Residential child care can be stressful at times and often residential child care staff feel their work is not held in high esteem. They are required to provide a caring service for children who often present demanding and difficult behaviour. The unsocial hours they have to work, which makes normal family life difficult for them, and the lack of support they sometimes receive can contribute to a high turnover in some centres. There is need for centre managers to pay more attention to the provision of support and supervision for care staff, so that they can improve their practice and know that their contribution is valued. In turn some managers have been given limited opportunities to attend courses on management methods where this is the case the situation needs to be rectified.

4.7 Purpose and Function of Centres

Although each centre did have a statement of purpose and function, some of these were identical for different centres in a health board area and did not reflect the essential differences in the services that they could offer to children. They were not always being adhered to when children were being considered for admission. It is acknowledged that where the total stock of residential care provision is limited it may not always be possible for a centre to adhere closely to the statement of purpose and function. However, it is worth emphasising that a well organised residential child care service which is responsive to the needs of children will set out clearly for each of its centres their particular purpose and function, including the part they will contribute to the board's overall child care provision and ensure that the staff, referrers, children and their parents are aware of its contents. Consequently, the managers and staff will be better able to gear their efforts to ensuring that the particular needs of those referred to the centre are properly addressed.

4.8 Views of Children and their Parents

The United Nations Convention on the Rights of the Child (Article 12) makes clear that the child who is capable of forming his or her own views should be assured of the right to express those views freely in all matters affecting him or her and that those views should be given due weight in accordance with the age and maturity of the child. It is clear the expectation is that opportunity should be provided for the child to be heard in any decisions being taken which affect the child. Young people's experience of being consulted is spasmodic and inconsistent. Relevant information needs to be made available to children and parents so as to ensure that they are enabled and empowered to give informed views. Some centres are better at providing information to and consulting with children and their parents than others. There is, however, room for improvement in this area. Opportunities exist for improving consultation through ensuring greater involvement of children and their parents in the development of care plans and inviting their participation in reviews and through arranging periodic children's meetings within residential centres. Managers should ensure that their expectations of involving children

in consultation relating to decisions affecting their lives are clearly understood by staff and monitor the extent to which this expectation is being met.

4.9 Leaving Care

While in some centres good work is being done to prepare children for leaving care either through the direct work of residential care staff or through contracting the support of a specialist leaving care service, very few had a specific leaving care policy. Energy and resources applied to the preparation of older children for living independently in the community and in preparing other children for a new placement, whether at home or in another out of home setting, are not only sound investments but essential in enabling them to cope when the transition takes place. Too many children from the care system end up with problems in the community with which they are unable to cope. It is essential that boards apply support services to those children leaving care in proportion to the needs they have to ensure that their first steps into adult life can be taken with greater assurance of success.

4.10 Finally

It should be acknowledged that the standard of work in community based residential child care centres will impact on the numbers of children needing high support and secure care. Resources directed at the improvement of care provision in community based centres must inevitably be better for children and families and ultimately achieve better value for money.

