

Statutory foster care service inspection report

Health Information and Quality Authority
Regulation Directorate monitoring inspection
report on a statutory foster care service under the
Child Care Act, 1991



Name of service area:	Dublin Mid-Leinster – Dublin South Central (DSC)	
Dates of inspection:	29 November – 1 December 2016 6 – 7 December 2016	
Number of fieldwork days:	5	
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Type of inspection:	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced <input checked="" type="checkbox"/> Full <input type="checkbox"/> Themed	
Inspection ID:	MON-0018345	

About monitoring of statutory foster care services

The Health Information and Quality Authority (HIQA) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

HIQA is authorised by the Minister for Children and Youth Affairs under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency and to report on its findings to the Minister for Children and Youth Affairs. HIQA monitors foster care services against the *National Standards for Foster Care*, published by the Department of Health and Children in 2003.

In order to promote quality and improve safety in the provision of foster care services, HIQA carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of HIQA's findings.

HIQA inspects services to see if the National Standards are met. Inspections can be announced or unannounced.

This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child-centred Services	<input checked="" type="checkbox"/>
Theme 2: Safe and Effective Services	<input checked="" type="checkbox"/>
Theme 3: Health and Development	<input checked="" type="checkbox"/>
Theme 4: Leadership, Governance and Management	<input checked="" type="checkbox"/>
Theme 5: Use of Resources	<input checked="" type="checkbox"/>
Theme 6: Workforce	<input checked="" type="checkbox"/>

1. Inspection methodology

As part of this inspection, inspectors met with children, parents and or guardians, other agencies and professionals involved in foster care services. Inspectors observed practices and reviewed documentation such as care plans, relevant registers, policies and procedures, children's files and staff files.

During this inspection, the inspectors evaluated the:

- quality of care and safety of the service
- organisation and management of the foster care service
- assessment of foster carers
- safeguarding processes
- effectiveness of the foster care committee
- effectiveness of interagency and multidisciplinary work
- oversight of children placed with non-statutory agencies
- outcomes for children.

The key activities of this inspection involved:

- the interrogation of data
- reviewing of policies and procedures
- reviewing of 112 children's case files
- the review of 64 foster carers' files
- meeting with 17 children and 36 carers
- meeting and telephone conversations with five parents and two grandparents
- meeting and interviews with 45 social workers
- meeting and interviews with seven social work team leaders
- meeting with five aftercare workers
- interviews with three principal social workers
- interview with the area manager
- interview with the chairperson of Tusla foster care committee
- attendance at five planning/review meetings, including child-in-care reviews, a foster carer review, a reunification planning meeting and professionals meetings
- visiting seven foster care homes.

Acknowledgements

HIQA wishes to thank the children, parents, staff and managers of the service for their cooperation with this inspection and foster carers and children who welcomed inspectors into their homes.

2. Profile of the foster care service

2.1 The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children and Youth Affairs. The Child and Family Agency Act 2013 established the Child and Family Agency with effect from 1 January 2014.

Tusla has responsibility for a range of services, including:

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

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the chief operations officer, who is a member of the national management team.

Foster care services provided by the Tusla are inspected by HIOA in each of the 17 service areas. The Tusla also places children in privately run foster care agencies and has specific responsibility for the quality of care they receive.

2.2 Service Area

The Dublin South Central Area is providing services to areas in Dublin South City and Dublin West, including Dublin South Inner City, Rialto, Inchicore and areas of the City including Ballyfermot, Clondalkin, Rowlagh, Palmerstown and Lucan.

The total population of the area is 261,041. 23% of this figure, which is 60,304, are under the age of 18 years of age. Please see (Figure 1) breakdown of age profiles and totals:

Figure 1. Age profile of under 18s in Dublin South Central area

Age:	Total
0-4 years	19,008
5-9	15,712
10-14	14,224
15-18	11,360

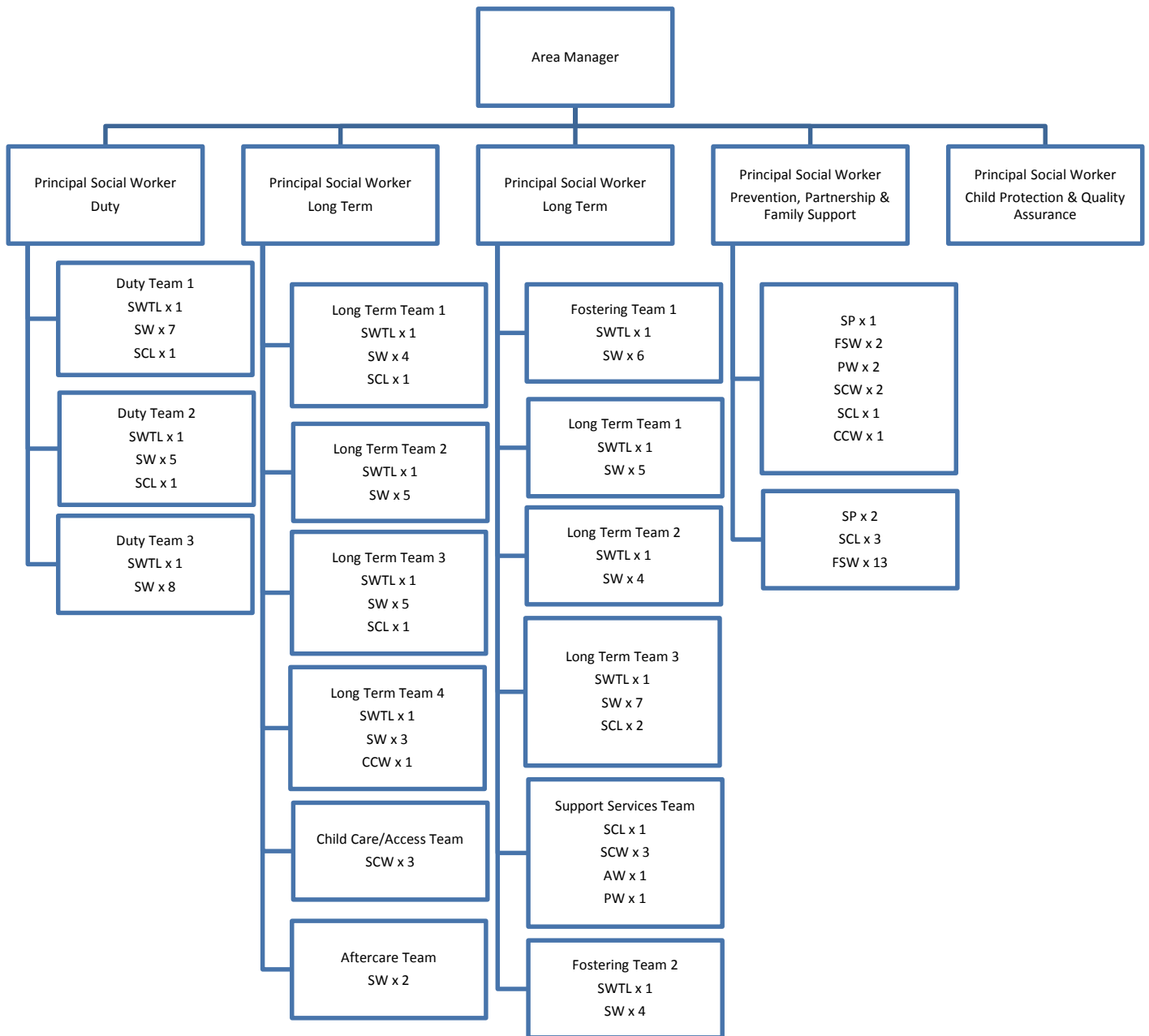
Census figures (2011) show that these areas have a greater number of very young children (0-4 years) than average with the highest number of the population in the 30-34 years age group bracket. Irish Nationals accounted for the majority of people living in these areas with Polish, UK Nationals and Lithuanians being the highest number of non-Irish Nationals. South County Dublin also has the second highest number of members of the Traveller Community living in the area. The main religion within the area is Roman Catholic followed by Church of Ireland, Islam and Presbyterian. The Pobal 2011 deprivation index cited some areas within the catchment as being 'very disadvantaged' and 'Extremely disadvantaged'.

At the time of this inspection, according to the information provided by the Agency, there were 351 children in foster care in Dublin South Central service area being cared for by 154 foster carers and 119 relative carers, in a total of 273 households. All 351 children (100%) had an allocated social worker. 199 foster carers (73%) had an allocated link worker. The service had placed 81 children (23%) in non-statutory foster care placements. There were 10 children (3%) waiting for foster care placements.

There were waiting lists in the Area for transfers of cases to other areas, assessments and approvals of foster carers, matching of children to long-term placements and for allocation of fostering link workers to foster carers.

The area is under the direction of the Service Director for Tusla, Dublin Mid Leinster and is managed by the Area Manager

Figure 2. Organisational structure of Statutory Foster Care Services in DSC Service Area*



Key: SWTL – Social Work Team Leader
 CCW – Child Care Worker
 PW – Project Worker

SW – Social Worker
 SCW - Social Care Worker
 FSW – Family Support Worker

SCL – Social Care Leader
 AW – Access Worker
 SP – Senior Practitioner

* Source: The Child and Family Agency

3. Summary of inspection findings

The Child and Family Agency (Tusla) has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in foster care require a high-quality service which is safe and well supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This report reflects the findings of the inspection, which are set out in Section 5. The provider is required to address a number of recommendations in an action plan which is published separately to this report.

In this inspection, HIQA found that of the 26 standards assessed:

- no standards were exceeded
- one standard was met
- 20 standards required improvement
- significant risks were identified in relation to five standards.

This report sets out the findings of the inspection of the Dublin South Central foster care service. Overall, there was a lack of placements in the area and social workers sought placements within children's families and communities. However, a lot of children's placements were crisis led. Inspectors identified a number of serious risks over the course of the inspection, and the following risks were escalated at the end of the fieldwork:

- long delays in the commencement and completion of Section 36 assessments, and in achieving a decision from the foster care committee — some children have been placed since as far back as 2012 without a decision being reached.
- decisions to repeat Section 36 assessments of carers in cases where, while the children remained in their care, completed comprehensive assessments had already concluded that the applicants were unsuitable and or the assessment had indicated serious concerns for the potential long-term safety and well-being of the child.
- decisions to extend Section 36 assessments for prolonged periods for relative foster care applicants who had not appropriately engaged in the assessment process where potential and or known risks existed.

- records did not reflect that the system in place to manage allegations against foster carers ensured adherence to *Children First: National Guidance for the Protection and Welfare of Children* (2011) and that investigations were completed in a timely manner with appropriate safeguards in place for children.
- there was no system in place to ensure all staff were vetted in line with Children First (2011) and Tusla's own recruitment policy.

Overall, on a day-to-day basis, social workers promoted and respected children's rights and children were supported to maintain good relationships with their families. There was respectful communication with children and families. The vast majority of children had warm relationships with their foster families and were involved in a range of hobbies and extra-curricular activities similar to their peers.

All of the children had an allocated social worker. Some children had experienced a number of changes in social worker over a short period of time which impacted on their relationship with them. The area had prioritised children having an up-to-date care plan in 2016. At the time of inspection 40 children (13%) did not have an up-to-date care plan, which was an improvement from 50% who did not have an up-to-date care plan at the start of the year. However, the quality of care plans varied from excellent to poor. The aftercare service was under-resourced and preparation for leaving care and aftercare plans were of poor quality.

Due to the limited number of placements, matching children to foster carers was not always possible and 98 children were placed outside of the local area at the time of inspection. In addition, the lack of culturally appropriate placements impacted on the services ability to meet the needs of children.

The assessments of general foster carers were generally of good quality but were not completed within the timelines identified in the National Standards. There was a regional initiative in place to process new general fostering applications. There was also an ineffective system in place to conduct reviews as reviews did not occur on a consistent basis in response to unplanned endings or where allegations had been made. The support received by foster carers varied, and supervision of carers required improvement.

The service was not managed effectively. While there was a clear management structure and lines of accountability, the service was crisis led rather than delivered in a planned manner. The service had significant challenges in completing assessments of relative carers, ensuring children had up-to-date care plans, ensuring foster carers had timely reviews, allocating link social workers and ensuring all allegations were managed in line with policy and Children First (2011). The foster care committee was not operating in line with Tusla policy. The committee was not

receiving all appropriate information, including disruption reports, allegations of abuse and foster carer reviews.

Use of resources required improvement. There were a number of unfilled posts within the service. In addition, placements of children outside of the area and social workers continuing to support young people over the age of 18 meant that social workers spent a considerable amount of time travelling to and from foster placements to meet with children and supporting young people who would have been more appropriately supported by an aftercare service, respectively.

Furthermore, training opportunities for staff had improved but supervision required improvement.

4. Summary of judgments under each standard and or regulation

During this inspection, inspectors made judgments against the *National Standards for Foster Care*. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

<i>National Standards for Foster Care</i>	Judgment
Theme 1: Child-centred Services	
Standard 1: Positive sense of identity	Requires improvement
Standard 2: Family and friends	Requires improvement
Standard 3: Children's rights	Requires improvement
Standard 4: Valuing diversity	Requires improvement
Standard 25: Representations and complaints	Requires improvement
Theme 2: Safe and Effective Services	
Standard 5: The child and family social worker	Requires improvement
Standard 6: Assessment of children and young people	Requires improvement
Standard 7: Care planning and review	Requires improvement
Standard 8: Matching carers with children and young people	Requires improvement
Standard 9: A safe and positive environment	Requires improvement
Standard 10: Safeguarding and child protection	Significant risk

<i>National Standards for Foster Care</i>	Judgment
Standard 13: Preparation for leaving care and adult life	Requires improvement
Standard 14a: Assessment and approval of non-relative foster carers	Requires improvement
Standard 14b: Assessment and approval of relative foster carers	Significant risk
Standard 15: Supervision and support	Requires improvement
Standard 16: Training	Requires improvement
Standard 17: Reviews of foster carers	Significant risk
Standard 22: Special Foster care	Requires improvement
Theme 3: Health and Development	
Standard 11: Health and development	Requires improvement
Standard 12: Education	Meets standard
Theme 4: Leadership, Governance and Management	
Standard 18: Effective policies	Requires improvement
Standard 19: Management and monitoring of foster care agency	Significant risk
Standard 23: The Foster Care Committee	Requires improvement
Standard 24: Placement of children through non-statutory agencies	Requires improvement
Theme 5: Use of Resources	
Standard 21: Recruitment and retention of an appropriate range of foster carers	Requires improvement
Theme 6: Use of Information	
Standard 20: Training and Qualifications	Significant risk

5. Findings and judgments

Theme 1: Child-centred Services

Services for children are centred on the individual child and his/her care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.

Summary of inspection findings under Theme 1

The rights of children were generally upheld in their daily lives and in their interactions with the fostering service. Overall, children maintained positive relationships with their family but sibling groups were not always placed together in line with their care plan. Children with a disability received appropriate support from their foster carers. However, not all children were placed with foster carers from their own cultural, ethnic or religious backgrounds and measures in place to ensure children's diverse needs in this regard were insufficient.

Not all complaints were effectively managed. Deficits were identified in recording and monitoring of complaints as well as in the information provided to children, parents and carers.

Children's rights

Children were treated with dignity and respect and were encouraged to develop their abilities and to pursue interests similar to their peers. Inspectors found that social workers were child-centred in their approach to children's care on a day-to-day basis. Inspectors who met with children and visited their foster homes found that they were provided with appropriate levels of personal care and they were enabled to be independent, appropriate to their age and individual needs. However, the promotion of children's rights needed to be more clearly represented in records and some practices.

Children told inspectors that they were encouraged and enabled to develop their abilities and to pursue interests. They were consulted in decisions about their care, and inspectors found that their views were heard and given due weight in accordance with their age, stage of development and individual needs.

However, the information provided to children about their rights was limited. Children who spoke with inspectors were not aware of their rights to access information held about them nor did they all have an age appropriate awareness of how to make a complaint. In addition, due to physical constraints within some

carers' homes, not all children had access to private space that give them opportunities to be alone.

Children had access to advocacy services such as Empowering People in Care (EPIC), but the information provided to children in relation to such services was minimal. A number of children had a court appointed guardian ad litem who advocated on their behalf, and inspectors found that social workers advocated on behalf of children and families in a variety of ways. For example, advocating for children to access specialist services or additional supports, when required.

Diversity

The quality of care provided to children with diverse needs varied. Inspectors reviewed a range of cases where children were from diverse ethnic or religious backgrounds or had a disability.

Children with a disability had good access to appropriate services and most services were provided consistently. Inspectors found that the particular needs of children with disabilities were recognised and met. Additional supports and services, including equipment, were provided to ensure children with a disability maximised their potential.

Some children were placed in culturally appropriate placements, while others were not. Where children were with carers from their own cultural, ethnic or religious groups, work undertaken to encourage children to understand and appreciate their heritage was good. Inspectors saw examples of extensive and focused work with children to ensure their family beliefs were incorporated and promoted within their foster care placement. The service operated a shared rearing scheme (SRS), which provided foster care placements for children from the travelling community with foster carers who were members of the travelling community. Inspectors found that the culture, identity and values of the children's family of origin were respected and promoted when they were in an SRS placement.

However, the service was challenged to meet the cultural needs of children who were not placed in culturally appropriate placements. While some measures were put in place to address some children's needs, this was not the case for others, and the measures were found to be largely tokenistic and inadequate. Inspectors found that some social workers were unclear in relation to religious requirements for children from non-Christian religions. This led to foster carers not being provided with sufficient information or being clear on how to meet the needs of these children.

Measures put in place to ensure children had a positive sense of identify and that their families' beliefs were promoted were insufficient. Inspectors found that, in some cases, despite clear requests and expressions of concern by parents and evident difficulties experienced by children with regard to maintaining a positive

sense of identity, this was not identified by social workers as a priority need or highlighted as part of children's care plans. Inspectors found that, in some cases, despite clear requests by parents in relation to attendance at religious services and dietary preferences, their wishes were not facilitated within children's foster care placements.

Family and friends

Children's relationships with their families were respected and, in the majority of cases, contact with family was identified as the main priority for children by their social workers. When children were taken into care, relative foster care placements were routinely considered for children in the first instance. The service had 115 children in relative care placement at the time of inspection. Efforts to identify and secure an appropriate relative placement were observed in children's case file records.

Significant efforts were made to secure and maintain placements for sibling groups together. The service had 64 sibling groups in foster placements together. However, where siblings were not placed together, reasons for this were not clearly outlined in children's care plans and some social workers did not know the reason why sibling placements had not been considered. In most cases where siblings were not placed together, foster carers made arrangements for them to have additional contact, often within their foster care homes.

Family contact arrangements were clearly set out in children's care plans and were subject to regular review. Inspectors found that the family contact plans sampled were detailed and included specific arrangements, such as location, transportation, duration and supervision arrangements, as appropriate. Inspectors found that children and families were consulted about family contact arrangements and there were a number of appropriate facilities available for family visits to take place.

Children's wishes were respected and inspectors saw examples of good work undertaken with children by their social workers to explain or review decisions relating to family contact. Most parents who spoke with inspectors were happy with arrangements in place for visits with their children and told inspectors that, when issues or difficulties arose, social workers were supportive and accommodated changes as required. A small number of family visits took place in the children's foster care homes.

Due to the lack of available general foster care placements within the area, priority could not be given to placing children in their local community. In total, 98 children were in placements outside of the area, with some a long way from their homes. This had the potential to negatively impact on their contact and relationships with family and friends.

Children were facilitated where possible to remain in their school placements. Even when children were placed outside of their own communities, if geographical distance allowed, supports were put in place for foster carers to facilitate transporting children to and from school.

Where children availed of respite foster care placements or had multiple admissions to foster care, efforts were made to ensure continuity of care.

Communication

The quality of communication with children and families was good. Inspectors found that there was good collaboration between professionals, children and families. Social workers engaged the services of interpreters to aid with communicating with children and or families who required this service. This included sign language and spoken language interpreters. Inspectors observed social workers interacting with children in a way that was sensitive and considerate of their level of communication skills. Social workers also supported children and families to understand information or decisions made relating to children's care.

There was age appropriate, child-friendly information relating to children's rights available in the area, and a plan for ensuring this was provided to all children was being implemented.

Complaints

Not all complaints were well managed. The area had introduced the new national Tusla complaints and feedback policy 'Tell Us' in September 2016. In line with good practice, the team managed complaints locally where possible. Data provided by the area identified that there had been 13 complaints in the last 12 months. However, inspectors identified a number of other complaints in files that were not identified or managed as complaints.

Inspectors found that some carers and children were not clear on the procedures for making a complaint. Some foster carers had received information on the new policy but others had not. In addition, some social workers were unclear about the policy. Social workers told inspectors that they had not received training on the new process.

Information provided to children on complaints required improvement. Children who spoke with inspectors did not have an understanding of the complaints procedure nor had they received written information. However, all children spoken with identified an appropriate adult to whom they could confide should they have a difficulty. Inspectors saw examples of complaints made by children which were appropriately identified as such and responded to comprehensively and effectively in an age-appropriate and child-centred manner.

The system to record and resolve complaints required improvement. There was a central register of complaints. A review of the complaints register found that the complaints policy was not implemented effectively in a significant number of cases. Complaints were not dealt with in a timely way, and full records in relation to the management of complaints, including correspondence to complainants, level of satisfaction of the complainant and details of resolutions or action taken or agreed, were not routinely recorded. In addition, there was no system in place to centrally record complaints that were managed locally. This practice meant that the area did not trend issues, responses or outcomes to inform learning and avoid repetition.

Theme 2: Safe and Effective Services

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs. In order to provide the care children require, foster carers are assessed, approved and supported. Each child receives the supports they require to maintain their wellbeing.

Summary of inspection findings under Theme 2

This inspection found the quality of the service provided to children and families varied significantly. Some children experienced comprehensive and ongoing assessment of their needs, along with good co-ordination of services. The quality of care planning was mixed, and, while children's needs were mostly met, some care plans did not adequately reflect their needs or the required actions to address these.

All children had an allocated social worker. While not all children had an up-to-date care plan or had statutory child-in-care reviews as required, there had been a significant improvement in this regard in the 12 months prior to inspection. Not all young people were receiving an aftercare service in line with Tusla policy

Where foster care assessments were completed, they were of good quality. However, significant risks were identified in relation to bringing some relative foster care assessments to their conclusion and reviews of foster carers were not taking place following an allegation or placement ending.

Child protection concerns were not always managed in line with Children First (2011) guidance. The management and investigation of specific concerns about foster carers was not sufficiently robust, and improvements were required regarding measures in place to safeguard and protect children from abuse.

Assessment and care planning

The child and family social worker

The service fulfilled some but not all of its statutory requirements. All children-in-care had an allocated social worker at the time of inspection. Some children told inspectors that they had experienced a number of changes in social workers over the previous 12-24 months. Inspectors also identified this in reviews of some children's files. This had an impact on the quality and continuity of care that children received,

interfered with the provision of statutory visits and completion of children's care plans and compromised the building of trusting relationships.

Children liked their social worker. They told inspectors that they were confident their social workers would support their wishes and felt that they saw enough of their social worker. Foster carers identified that they found changes in children's social workers and the high turnover of staff difficult. Foster carers told inspectors that they experienced difficulties with coordinating children's various care needs when social workers who went on extended periods of leave were not replaced. Some carers expressed concerns about the impact that multiple changes in social workers had on children's ongoing/developing relationships with their social worker.

Children were not always visited in line with regulations. Inspectors found that there had been an improvement in regulatory visits in the three months prior to inspection. At the time of inspection, inspectors found a small number of children who had not had a visit from their social worker within the regulatory timeframes or who had not met their current social worker.

Not all children's records were appropriately maintained. Inspectors reviewed children's case files, including records of visits, and found that details contained in records varied. Some case notes were of excellent quality and provided a clear, comprehensive overview of children's interactions with their social workers as well as the opportunities provided to children to have input into decision-making on various aspects of their care. Whereas others were of poor quality, lacked substance and frequently did not reflect vital details necessary to maintain an account of the child's time in care. Details of visits by social workers did not identify if children were visited in their foster homes, if they were seen alone or if they had the opportunity to discuss concerns or indeed participate in age appropriate decision-making relevant to their care.

Assessment of need

The quality of children's assessment of need required improvement. While the majority of children's needs had been assessed, some children's files contained comprehensive assessments but this was not consistently evident on all children's files. Some children's files contained detailed social work reports and or court reports outlining children's background, circumstances and needs, including comprehensive reports of health, emotional and behavioural and educational needs. However, many records did not reflect that children's care planning had been informed by comprehensive assessments of their needs.

Matching¹

There was an insufficient availability of foster care placements in the area to meet the needs of the foster care service. The number and type of placements available varied, which meant that compromises were made with respect to the quality and suitability of placements for children. Social workers and social work team leaders demonstrated a good knowledge of individual children's needs, and they told inspectors that this knowledge was the basis of information sharing and discussion with the fostering team when attempting to appropriately match a child with the carer. However, some placements were far from ideal, particularly relating to accommodation and location.

While 24 children's placements had ended in an unplanned manner, in the absence of disruption meetings, the management team were not in a position to say that poor matching had been a cause or not.

Care planning and review

Not all children had an up-to-date written care plan. Data provided to HIQA by the area indicated that 40 children (13%) did not have an up-to-date care plan at the time of inspection. Inspectors found that a lot of work had been done by the team in 2016 to ensure that children had an up-to-date care plan as at the start of the year over 50% of children did not have a care plan. This improvement demonstrated a clear focus by the area social work team to address the deficits in care planning for children.

The quality of care plans varied greatly from excellent to poor. Some care plans showed that children and families, foster carers and significant others were consulted in drawing up of the care plan, and inspectors saw examples of care plans where children's views were represented and evident throughout their plans. However, other plans lacked the necessary information to guide or inform children's care. Many plans were unspecific or demonstrated a lack of progress from one plan to the next, had timeframes for actions were vague or cited as on-going, and had actions repeated on several plans. There were significant delays in completion of children's care plans following statutory reviews, and not all care plans were signed by relevant people.

Child-in-care reviews did not take place for all children within legally defined time limits. Data provided to HIQA by the area indicated that the child-in-care reviews for 33 children (11%) were overdue at the time of inspection. While many children's

¹ Matching is a process that ensures a placement is suitable to meet the assessed needs of a child. This usually occurs in general foster care placements, after the child has spent a minimum of 6 months in the placement. Relative care placements differ in that, the match has been identified at the time of placement and the child usually knows the carer with whom they are placed. The matching process involves an assessment of the match and the presentation of a report to the Foster Care Committee (FCC) recommending (or not) the placement is confirmed as a long-term placement.

files examined did not contain any minutes of child-in-care reviews, inspectors did review some and found, as with care plans and placement plans, the quality of these varied from poor to excellent. Templates used to record minutes of child-in-care reviews varied throughout the area, and inspectors found that records of actions or decisions agreed as part of a child-in-care review were not routinely documented. This was confirmed by foster carers.

Child-in-care reviews were child centred. Children told inspectors that they were involved in their care planning, and inspectors found that there was good consultation with children prior to and during their child-in-care reviews. Inspectors attended three child-in-care reviews and observed them to be child centred, focused, inclusive and effective. Children attended two of the three reviews that inspectors observed. Social workers completed age appropriate review forms with children who did not wish to attend their reviews, and these were given due consideration during reviews. Children told inspectors that they were confident that their views would be represented by social workers, and they were aware that they could attend if they so wished. Some children in long-term care felt that the forms to be completed for child-in-care reviews were not relevant to them and were not age appropriate for older children.

Relevant professionals involved in children's care, protection, education, health and development were invited to contribute to children's reviews as appropriate, and inspectors observed reports from relevant professionals being presented and considered at child-in-care reviews they attended. In some cases, these professionals attended the reviews.

Placement plans were not consistently completed within the area. Inspectors found a significant number of children's files examined did not contain any placement plans. Of those placement plans which were reviewed, the majority were of poor quality, unsigned and without any evident consultation or involvement of foster carers or link social workers.

Quality of care

The majority of children were well cared for and the foster care homes provided a safe, healthy and nurturing environment for children. All of the children seen by inspectors during home visits appeared well cared for, content and very much at ease as part of their foster families. Inspectors saw that children had sufficient toys, books, belongings and clothes and most children had their own bedrooms or shared with a sibling. Children told inspectors that they were happy in their homes, that they were encouraged, facilitated and supported to pursue their interests and had opportunities to participate in any hobby of their choice. Children told inspectors that they were supported and encouraged to maintain family links and friendships. However, it should be noted that inspectors only met with children placed within the

service area and, for a significant portion of the 98 children in foster placements outside of the service area, this was not always possible.

The quality of care provided to children with complex needs was generally good. Children received timely access to specialist services. Data provided to HIQA reflected that there were 16 children awaiting specialist services or support such as specific child-care work and therapeutic support. These children were prioritised by senior staff according to urgency of need. In cases where access to a service was not timely and it was a priority, private services were purchased and these were applied for and approved by the area manager. Social workers told inspectors that requests for funding for specialists services were typically supported, and children's access to such services was a priority for the area manager. Inspectors saw evidence of strong advocacy and good interagency work with other professionals in some children's files.

The level of support for foster carers caring for children who presented with behaviours that challenged was mixed. Respite supports were provided to many of these foster carers to support and maintain placements, and children had access to social care leaders and social care workers for some direct work and life story work, but this was not effective in a number of cases examined and behaviour that challenged was cited as the main reason for unplanned endings.

The availability of special foster care placements was extremely limited within this service area, but inspectors found that supports put in place for children with complex needs and their carers were good. Many foster carers supported children with complex behavioural and emotional needs and some cared for children with complex medical needs.

Foster carers were not routinely provided with specific training on children's complex needs but additional specialist therapeutic supports were provided, and case files showed that children with complex needs were subject to regular review. Respite arrangements were in place for some children, and external services were used to provide additional child-care and emotional supports to others. However, some children's complex needs had led to placement breakdowns despite additional supports as their needs required expertise beyond the ability of general or relative foster carers. In the majority of cases, these children were placed in private foster care or residential care placements.

Mechanisms in place to prevent unplanned endings were not effective. Data submitted by the area showed that 24 children's placements had ended in an unplanned way in the two years before inspection. The system for learning from placement endings was not effectively implemented and, as a result, causes for placement breakdowns were not routinely examined or identified. Inspectors found that disruption meetings, disruption reports or foster care reviews did not take place

and information to inform learning to improve the provision of stable, appropriately matched placements for children was not collated.

Preparation for leaving care and adult life

For any young person, the transition to adulthood and increasing independence can be difficult. For children-in-care, leaving care can be particularly overwhelming. The aftercare services within this social work area was vastly under resourced to provide quality, specific supports to young people to help them to develop the skills, knowledge and competency necessary for adult living.

Data provided to HIQA showed that 44 young people aged 16 years and older were being cared for within the foster care services and there was an additional 57 young people over the age of 18 years who remained in foster care placements. Of the 44 children aged 16 years and older, five were allocated an aftercare worker, 11 had been referred for allocation of an aftercare worker and 10 young people had leaving care plans. However, allocation of resources within the aftercare team could not always be deployed based on need or risks assessed by the social work team as court ordered appointments of aftercare workers took priority and dictated the allocation of much of the available resources. The majority of aftercare resources outside of those ordered by the courts were dedicated to young people who were most at risk of placement breakdown or who would not have supports available beyond 18, which often were not children in foster care placements.

Social workers supported young people to prepare for leaving care. Due to the aftercare service being under resourced, much of the preparatory work and development of skills was the responsibility of the foster carers, with some guidance from social workers if required. This system for preparing young people for life after care placed a burden on social work resources as they continued to provide good quality and high levels of supports to young people far beyond their 18th birthday without the option of allocation to a dedicated aftercare worker.

Preparation for leaving care and aftercare plans were of poor quality. Inspectors found that while there were some records to indicate that social workers had begun to discuss and prepare young people for planning for their future, many did not have plans on file. Inspectors found that the preparation for leaving care needs assessments and plans that were in place were of poor quality, with the majority incomplete, unspecific and with no evidence of consultation and involvement of young people, their families or foster carers. Plans were not timely and did not clearly reflect agreed future living arrangements as required.

Foster carers – assessment

The timelines around the assessment and reviews of foster carers required improvement. General foster care assessments were generally of good quality. They

contained relevant health and safety assessments as well as medical checks, references and An Garda Síochána vetting. However, of those assessments reviewed, inspectors found that none were completed within the required timeframes. Some assessments reviewed showed delays of over four years between application and completion of assessment for approval by the foster care committee. Records did not reflect valid reasons for delays or detail efforts to complete assessments. Foster carers told inspectors that the length of time the assessment took to complete caused a lot of stress and many spoke of significant changes in circumstances from the time of their initial application to the completion of the assessment. Foster carers received written information from the foster care committee in relation to their approval and were aware of their right to appeal decisions and recommendations.

A regional assessment fostering team (RAFT) was completing all general assessments since January 2015 as a means of responding quickly to enquiries and progressing them to application and completion of full assessments for presentation at the foster care committee. The team leader from RAFT identified that the team had completed five general foster carer assessments in the 12 months prior to inspection and that were completed within the required timeframe.

Relative foster carers were not assessed in a timely way. Nine relative carers had been approved in the 12 months prior to inspection. In a significant number of cases, full comprehensive assessments of relative foster carers were outstanding for protracted periods of time, placing some children at significant risk and leaving these children and carers uncertain as to the continuation of their placements. Of those examined, inspectors found that some children were in placements for up to six years prior to completion of a comprehensive assessment.

Screening checks² on relative carers were of good quality. Inspectors found this screening included home visits, references and local An Garda Síochána checks prior to placing children. They reflected considered decision-making, and a number of the cases examined appropriately recommended that the carers being considered were not suitable.

Where relative foster care assessments were completed, the majority were of good quality. However, none of the cases reviewed had been assessed within the 16 week timeframe set out in the standards.

At the time of inspection, nine relative foster carers did not have an allocated social worker and were awaiting an assessment but had children placed with them (four on a respite basis). There were another 35 relative carers awaiting completion of their assessment — some with children placed with them as far back as 2012 without a

² Screening checks include viewing the environment, checking social work records, speaking to referees and consulting with An Garda Síochána to make sure there is no information that would raise concerns about someone's ability to safely care for a child. These checks should happen before a child moves in with a family.

decision being reached. In addition, inspectors found a small number of unapproved relative carers who had not appropriately engaged in the assessment process, where potential or known risks existed and where there was no strategy in place to manage these situations.

Allowing a child to be cared for by an un-assessed and unapproved relative carer for several years posed a significant safeguarding risk. In addition, in the event of an assessment finding their carers unsuitable or should the foster care committee refuse an application and it became necessary to remove a child, the child is open to further change and uncertainty. HIQA sought assurances from the service director in relation to the timelines of relative carer assessments and was subsequently informed that a strategy had been put in place, with timelines, to address outstanding assessments.

The area did not ensure that all children were appropriately placed with carers that were in a position to meet their identified needs. Inspectors identified a small number of carers who had been refused by the foster care committee or where their foster care assessment did not recommend their suitability as carers but continued to care for children despite concerns and known risks. These children remained in placements for significant periods despite risks having been identified early into their placements. Inspectors sought assurances from the service director in relation to cases where recommendations of relative foster care assessments had been overturned that appropriate action had been taken to address the identified concerns and/or proceed with seeking approval through the foster care committee. The service director confirmed in writing that appropriate steps were being taken in relation to these cases.

Garda vetting of foster carers did not always take place in line with National Standards and Tusla policy. Data provided to HIQA showed that there were six foster carers whose vetting was outstanding; however, at the end of the fieldwork, this had been progressed. While the National Standards and Tusla policy requires that carers are re-vetted on a three yearly basis, this was not occurring on a consistent basis. The area identified that re-vetting was outstanding on 107 foster carers.

In addition, inspectors found that Garda vetting was not always obtained for other adults living with or with unsupervised access to children.

Signed contracts were available on carers files.

Supervision and support

Not all foster carers received adequate support and supervision. There were inadequate supports in place to ensure that foster carers had access to the appropriate levels of information, advice and professional guidance required. The quality of supervision of foster carers was poor. Data provided to HIQA by the area

identified that there were 74 foster families without a link worker. This impacted on the level of support and supervision for all carers as the resources available were limited and stretched. Children's social workers told inspectors that this deficit also impacted on the direct work being completed with children as they had to provide supports and interventions to children's foster carers at times, which would otherwise have been done by allocated link workers.

There was a duty system in place for unallocated foster carers but it was inadequate. The area had implemented a practice of phoning unallocated foster carers on a rolling basis. However, details of contact by duty social workers or failed attempts to make contact with carers were not consistently recorded. The duration of time carers may have gone without a visit or contact with a social worker could not be tracked and was not being monitored by staff. Inspectors found that when social workers successfully made telephone contact with carers, this was a check-in, as opposed to being used to identify issues requiring support or to provide any level of supervision. Carers' case notes were not updated with any specific details, and issues or concerns noted by previous social workers on case files were not addressed.

Inspectors also found a small number of examples where foster carers who had children placed with them had not been visited by a link social worker in the last two to three years and others where there was no record of any form of support or supervision for more than 18 months.

Foster carers spoke very highly of their link workers. While all foster carers who met with inspectors had experienced periods where they were not allocated a link worker, they all said that when allocated, link workers were helpful, supportive and challenged decisions or addressed issues if and when they arose. However, there were no support groups for foster carers or their children in the area. Foster carers told inspectors that these had been in place in the past and that they missed this source of support.

Social workers and social work team leaders often provided out-of-hours support to foster carers and children during periods of instability or if circumstances arose which required the availability of such additional supports. However, this was agreed on a case-by-case basis and the area did not provide an out-of-hours service to support foster carers in the event of an unforeseen crisis.

Training

The area provided good training opportunities for foster carers. There was a strategy in place, with a specific group established who had responsibility for planning, coordinating, evaluating and facilitating training for foster carers. This group included both social work staff and foster carers. The training programme took note of assessed training needs and facilitated training requests by carers. Training

evaluation forms were completed, and it was clear that the information gathered was collated and informed future training topics.

There was varying levels of attendance by carers at training events. Carers told inspectors that they got written information in relation to training opportunities and chose which to attend. Inspectors found a number of examples of carers who had no record of attendance at any training since their approval as foster carers. In addition, inspectors found examples of carers being presented to the foster care committee who had not attended the foundations for fostering training, which is a mandatory training requirement for all applicants going through assessment.

As foster care reviews were not occurring as required, there was no appraisal of carers' training needs and no mechanism for ensuring that skills were maintained or enhanced or, indeed, that issues or training needs were being identified and addressed.

Records of attendance at training required improvement. While attendance sheets were maintained, link workers did not maintain adequate records on carers' files of when carers attended training.

Reviews of foster carers

Foster care reviews were not taking place as required and this presented a significant risk. Regular reviews of foster carers to assess their continuing capacity to provide high quality care and to assist with the identification of gaps in the service were not occurring. Reviews were not occurring following serious incidents, complaints, allegations or indeed placement breakdowns, and information on such incidents was not routinely notified to the foster care committee. Data submitted to HIQA said that six foster care reviews had taken place in the 12 months prior to inspection, 15 in the three years prior to inspection and 161 foster carers (60%) had not undergone a review in the last three years as required.

Where reviews had taken place, the quality varied from very good to inadequate. Inspectors found a number of records of reviews which were vague and did not include all required information, for example, details of training to be undertaken in the period up to the next review and up-to-date medical reports or Garda checks. Furthermore records did not clearly reflect that the foster care committee had been informed of the outcomes of reviews.

Health and safety assessments were not updated as required, and, for some foster carers, health and safety risks had not been assessed for up to 20 years. As a result, actual or potential risks associated with some homes were not identified and managed.

Social workers and team leaders told inspectors that reviews of foster carers had been identified as a priority for the service area. However, an appropriate system for

prioritising carers for review, which considered risks and safeguarding, had not been established. While some carers were prioritised for review as a result of allegations or concerns identified, the risks associated with carers who had not undergone a review since their approval or for considerable periods of time had not been measured. Children continued to be placed with foster carers who had been subject to an allegation and or experienced an unplanned ending without having undergone a foster care review.

Safeguarding and child protection

The measures in place to safeguard and protect all children in foster care required significant improvement. The service did not consistently implement processes as outlined in Children First (2011), and foster carers who met with inspectors were unsure of their responsibilities under Children First (2011).

There were some safeguarding measures in place. All children had an allocated social worker at the time of inspection. Social workers undertook work with children so they understood why family visits were supervised, where appropriate. Absence management plans were observed in children's files. There was a protected disclosure policy in place, and while not all staff interviewed was aware of it, they were all clear that they would approach their team leader or principal social worker if they had any concerns.

Carers, as part of the foundation for fostering course received training on safe care practices. However, not all carers attended this training. In addition, the area offered carers opportunities to attend children first training but poor records were maintained of those who attended and there was no oversight to ensure those who required the training attended. As previously identified, other safeguarding measures, such as the vetting of carers and other adults living in or with unsupervised access to children, were not consistently undertaken. Furthermore some relative foster carer assessments went on for protracted lengths of time, and foster carers were not always allocated a link worker.

Inspectors found that the area did not have a clear policy on the management of allegations of abuse and not all allegations were managed in line with Children First (2011). Inspectors escalated the lack of a timely notification to An Garda Síochána to the Principal Social Worker, who addressed the issue immediately through the development of a guidance note which was implemented during the inspection. Many staff members were also unclear about their responsibilities under Children First (2011).

Social workers told inspectors that there was confusion and uncertainty amongst the team on how to manage welfare concerns and allegations. Three different guidance documents on the management of allegations were provided to inspectors as part of

the inspection. The service director advised that, in the absence of a national policy, the Dublin Mid-Leinster region was developing its own interim policy.

Oversight of allegations was not effective as there was a failure to ensure that all concerns were recorded and tracked appropriately. Data submitted to HIQA identified that there had been 27 child protection and welfare concerns or allegations made about children in foster care in the 12 months prior to inspection. Some of these related to foster carers. Inspectors found details of three further concerns referenced in supervision files and case notes which had not been identified on the data provided and sought further information from relevant social workers. While two allegations had been appropriately managed, a professionals meeting was subsequently planned for the third.

Practices in the management of concerns or allegations against carers were found to be inadequate and posed significant risks to children. Inspectors found that in a number of cases, there was a lack of appropriate follow through or the response to reported concerns was not timely. This included delays in categorisation and prioritisation of allegations, meeting children and identifying an independent social worker to undertake the child protection assessment.

Inspectors sought assurances from the service director in relation to the mechanisms in place to ensure that all allegations against foster carer's had been appropriately investigated in line with Children First (2011). The service director responded with a plan to undertake a review of all outstanding allegations by the end of January 2017. In addition, principal social workers from the area would undertake a retrospective review of the concerns commencing in February 2017.

The foster care committee did not have oversight of allegations made against foster carers as allegations were not consistently notified to them in line with Tusla policy.

While inspectors found that visits to foster homes were prioritised following receipt of a concern and carers said they were informed about complaints/allegations, it was not always clear if children were spoken to alone on such visits.

Data submitted by the area identified that there had been 17 incidents of children going missing from care in the past 12 months. When children went missing from care, inspectors found that foster carers and social workers followed procedures and children's individual missing from care plans. Strategy meetings were held with An Garda Síochána, as appropriate.

Theme 3: Health and Development

The health and development needs of children are assessed and arrangements are in place to meet the assessed needs. Children's educational needs are given high priority to support them to achieve at school and access education or training in adult life.

Summary of inspection findings under Theme 3

While not all children's health records were up-to-date, children's primary healthcare needs were met. Children with complex medical needs were placed with foster carers appropriately supported and equipped to meet their needs. There was a high priority placed on the education of children, and children were encouraged to achieve their potential.

Healthcare needs

Children's primary medical and health needs were identified and met. However, while some children's files had comprehensive records pertaining to medical needs, many children's files did not contain up-to-date details of health checks and general medical information. Efforts to obtain missing immunisation records, medical histories or medical reports were not recorded in files, and this meant that key information about the health and wellbeing of children was not protected and maintained for their future.

Medical examinations were undertaken when children were admitted into care. Inspectors found that general practitioner and medical card information was recorded on children's files.

Children with significant health and medical needs received a good standard of care. Inspectors saw records of multidisciplinary team involvement in planning for these children and found good written and verbal communication between social workers and healthcare professionals. Foster carers told inspectors that they were supported to access health services by social workers who made and followed up referrals to specialist services.

The issue of consent to medical and dental treatment was clearly understood by foster carers. They were aware of their responsibility to notify the child's social worker about health issues or events concerning the child in their care.

Where children with complex medical needs were being cared for in foster care placements, inspectors saw evidence of foster carers being supported to make necessary alterations to their home in order to provide suitable accommodation to care for children. Specific complex needs such as a requirement for intensive specialised supports were facilitated. However, inspectors found that contingency

plans had not always been identified to ensure consistent service provision in these cases and found that some gaps existed in the provision of the required specialist supports. This issue was escalated to the principal social worker, who responded with an appropriate plan to address the consistent provision of the service.

Education needs

The vast majority of children had an educational placement. The educational needs of children in foster care were a high priority, and children were supported to attain their potential. Children who were placed outside of the area were supported, where possible, to maintain their school placements. For some children whose education had been disrupted due to periods of absence from school, inspectors found that social workers prioritised their timely re-engagement in education or training in collaboration with parents and foster carers. Foster carers told inspectors that social workers were proactive in aiding them to support school placements when difficulties arose. While the majority of foster carers took responsibility for the day-to-day support for children's education, it was evident from records examined that social workers were proactive in advocating for and ensuring children received educational assessments and supports as appropriate.

A review of case files demonstrated that children's educational needs were identified and addressed in the care planning process. School reports and attendance records were requested for each child as part of the statutory review, and these were found on case files reviewed by inspectors. There was evidence of educational reports on file for care plan review meetings and inspectors observed these reports being considered as part of children's statutory review meetings as well as follow up actions identified where necessary.

There was good communication and engagement between carers, professionals and schools. Foster carers were clear on their obligation to ensure that education concerns were brought to the attention of the social worker and schools in a timely manner and an effective plan of action agreed.

Children were aware of the supports available to them. Children spoke positively about school, and some children who had experienced difficulties spoke about the supports they had received to overcome these. Foster carers who met with inspectors were clear on their responsibility to promote children's education as well as to provide opportunities to develop social and life skills by encouraging participation in hobbies, interests and extracurricular activities.

Theme 4: Leadership, Governance and Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed and the system is subject to a rigorous quality assurance system. Services provided on behalf of the area are robustly monitored. The Foster Care Committee is a robust mechanism for approving both placements and foster care applications.

Summary of inspection findings under Theme 4

The management structures and systems within the foster care were not effective in ensuring there was equity and consistency in the quality of care across the service. There were significant challenges in ensuring children had good quality up-to-date care plans, managing allegations, completing assessments on relative carers, and carrying out timely reviews of foster carers. The governance arrangements of the foster care committee to ensure their oversight of allegations, unplanned endings and foster care reviews also required improvement.

Management structures and systems

There was a defined management structure in place with clear lines of accountability and responsibility. Inspectors found that the line management structure was clear to all staff, and staff across the service were aware of the roles and responsibilities of all grades of staff. However, systems in place to hold staff to account were not always effective. Staff told inspectors that they were held to account by their managers in a number of ways, for example, through supervision, performance reviews and on a day-to-day basis with respect to decision-making and social work practice. Inspectors found a number of national policies were not fully implemented in some parts of the service, for example, the caseload management tool, supervision, meeting timelines for managing complaints and management of allegations. In some cases, the area manager and service director were not aware of these issues and, therefore, were not in a position to hold the relevant staff to account.

In addition, the area manager position had been advertised nationally, and the current area manager was due to vacate her post on the day after the inspection finished. However, no interim arrangements for this vacancy had been identified at the time of inspection. Subsequent to the inspection, HIQA was notified that the principal social workers for the area would act in the position on a rotating one to two week basis.

Some staff members carried high caseloads and morale on some teams was low. The pace of work and high turnover of staff had taken its toll on team members. Unfilled posts were cited as a factor for a number of deficits within the service, for example, unallocated foster carers and delays in completing Section 36 assessments.

Management systems required further development and improvement. The area had a suite of policies in place to promote the provision of the foster care service which comprised of both national and local policies. Team meeting minutes identified that a number of policies, including the protected disclosure policy and the new complaints policy, had been discussed. However, a number of policies were under review or had not been fully implemented at the time of inspection. For example, the supervision, inter-area transfer and allegations against foster carers policy.

Some communication systems were good. Staff told inspectors that they received up-to-date information about the service through team meeting. Inspectors reviewed minutes of regular management meetings, team meetings and fostering forums and found that issues discussed included operational issues, service delivery, training and updates on policy development and implementation.

Planning the service

Planning for the service required improvement, in particular, the use of foresight and pre-emptive planning for areas of the service known to require additional resources or attention. Inspectors found that despite the management team being aware of a number of the deficits within the service area, collective planning was poor and in many respects the service was crisis led.

The service had a business plan for 2016 but had only achieved one of their priorities for foster care. These priorities included:

- increasing the number of approved statutory foster carers
- implementing a strategic approach to the provision of foster care as part of the alternative care strategy
- ensuring 100% of children in care had an allocated social worker.

The plan also identified as a priority the need to prepare for the Child Care (Amendment) Act 2015 requirements in relation to aftercare and the need to ensure full implementation and compliance with the caseload management policy as part of the Tusla retention strategy.

While the service had achieved the allocation of a social worker for all children in foster care other aspects of the service remained in crisis. A number of reasons were cited for these deficits, including protracted recruitment processes which were outside the control of the local management team, inability to fill vacant posts, the high turnover and consequential high level of inexperienced social workers, and

social workers continuing to provide care and support for young people over 18 years.

In addition, the availability of local general foster care placements was an ongoing issue for the service that had a range of implications and led to crisis management. Insufficient placements meant it was not possible for matching to be part of day-to-day practice. Inspectors found that social workers who had children placed in foster care outside of the area spent a significant amount of time travelling to visit children and this took them away from other direct work with children and families.

The combination of the lack of these resources compromised the delivery of a safe effective service.

Risk management

Risk management systems were not effective. While a number of significant risks were known to the service, inspectors found that the identified controls were not effective at reducing the risk. In addition, other risks, for example, the lack of availability of suitable placements, foster carer reviews not taking place and unallocated foster carers, had not been identified on the risk register.

Monitoring and oversight

Mechanisms in place to ensure a quality safe foster care service were not sufficiently robust. There had been developments at a national and regional level to improve the quality agenda, and the regional quality group were involved in the quality improvement framework.

The area was developing arrangements to promote compliance with National Standards, policies and procedure. A principal social work post was assigned with responsibility for quality and oversight of the service. To date, audits had been commenced by team leaders and principal social workers on children and foster carers files as part of supervision. The intention was to collate the findings and promote learning and improve quality. A working group had recently been established to work on promoting children's rights and ensuring children were aware that they could access their information.

Other aspects of the service were not used to learn and bring improvements. Despite the high number of unplanned endings, no analysis of these placements or review of the carers had been completed within the area to see if there was any learning. In addition, there had been no oversight of locally managed complaints within the service.

Therefore, the management team were losing an opportunity to identify if there were any trends that could be remedied. However, the Principal Social Worker for Quality Assurance told inspectors this was an area that she was now responsible for and that she would be providing oversight.

No formal external monitoring had been undertaken in the area up to the time of inspection. Inspectors were informed that a Tusla monitoring officer, who would be responsible for monitoring the service against the Regulations and National Standards, had only recently been appointed to the area.

There were no formal monitoring arrangements or reporting requirements in place with private foster care service providers to ensure ongoing compliance with child-care regulations and standards and that children received a high quality service. While there were individual contracts in place with foster carers and a high number of children were placed through non-statutory agencies, there was no service level agreement in place for private providers. Inspectors found that monitoring of these services and the quality of care provided varied on a case-by-case basis.

The foster care committee

The foster care committee was not in compliance with national standards and did not function consistently in line with Tusla policy. The membership of the committee was in line with the Tusla foster care committee policy. The committee was made up of appropriate people with expertise in child welfare and was chaired by an independent chairperson who had been appointed in February 2016. The committee met once a month and could also be convened more frequently if the need arose.

The committee made timely recommendations based on the assessment of potential foster carers which were presented to them by the fostering team. The chair told inspectors that social workers attended meetings as well as potential carers, including when an update or clarification was required.

The committee did not consistently receive referrals in relation to issues that should have been presented to them. The committee had received no disruption reports, which are reports completed after a child's placement has broken down. There had been 24 unplanned placement endings in the 24 months before this inspection. Inspectors found numerous examples of children placed outside of carer's approval status but these cases had not been referred back to the foster care committee to review their foster care approval status.

The committee was not meeting all of its governance functions. Inspectors found that the committee did not question that reviews were not being presented to them or ensure that there was a system for ensuring all allegations against carers were brought to the attention of the committee. This raised issues around how effective the committee was in ensuring children were living in appropriate placements that could meet their needs.

Inspectors received a copy of the annual report for 2015 and a review of the foster care committee policy and procedure which had been completed by the outgoing chairperson. Both of these reports outlined in detail recommendations for improvements required within the functioning and practices of the foster care

committee. However, neither addressed the significant deficits in relation to the reporting of allegations or unplanned endings, the absence of a mechanism to ensure that recommendations of the committee were implemented and the failure to complete timely assessments or reviews of foster carers.

Use of information

The information systems that operated in the area were not fit for purpose. In the absence of a national childcare information system, the area used a social work information system and Excel worksheets.

The information system did not assist the management team to have access to quality information. Data was manually gathered on a monthly basis in relation to children in foster care and was reported to the regional and national offices of Tusla. Inspectors found that data provided during the inspection was not always accurate. For example, the number of allegations against foster carers and the number of foster carers who had ceased fostering. The absence of an integrated system led to delays in staff accessing information in a timely manner.

The area held a register of children but it was not maintained in line with the regulations. For example, the register did not show the date when placements ceased or there were changes in particulars. The area also held a register of the panel of foster carers that was found by inspectors to meet the standards and regulations.

The quality of records varied from poor to good. Inspectors found significant gaps existed in case notes for some children and carers. Some files did not contain the necessary regulatory information and some records were not dated or signed. For example, key information such as child-in-care review meeting minutes and health records were not present on some children's files. Inspectors found that some carers' files were missing critical documents such as assessments, health and safety checks and confirmation of approval status.

Chronologies to assist staff in accessing a full history of the main issues and events in children's lives were not used.

Theme 5: Use of Resources

Services recruit sufficient foster carers to meet the needs of children in the area. Foster carers stay with the service and continue to offer placements to children.

Summary of inspection findings under Theme 5

There were not enough carers in the service to provide placements in line with standards, and there was an insufficient range of carers to meet the diverse needs of children. There were a number of children placed with carers contrary to national standards and a significant number of children placed outside of their local area.

Limited resources had an impact on the area's capacity to appropriately support foster carers and there was no effective retention strategy in place

Retention and recruitment of foster carers

There was an insufficient range of carers to meet the demands of the service, particularly with respect to the diversity of foster carers. Insufficient placements meant that the options for matching carers to children was limited and was not an integral part of day-to-day practice. Data provided by the area identified that 14 children were awaiting a foster care placement and 79 children had been placed in private foster care placements. In addition, contrary to standards, 34 children were placed with foster carers outside of their approval status and 10 carers had more than two unrelated children placed with them.

As a result of a shortage of carers, there was a reliance on out-of-area placements and 98 children were placed outside of the area. This had an impact on children having to live significant distances away from their own community as well as on social workers, foster carers and family members who had to travel considerable distances to ensure that children had visits as required.

The Dublin Mid-Leinster (DML) region of Tusla assessed general foster carers through the Regional Assessment Fostering Team (RAFT), and recruitment of general foster carers was their responsibility. RAFT had completed one regional recruitment campaign for foster carers in May 2016 and 13 information meetings for prospective carers in the last 12 months. Applications were progressed by the RAFT team in a timely manner and brought for approval to the foster care committee. The local fostering team had responsibility for completion of relative assessments and for the retention of all foster carers.

There was no effective retention strategy in place to develop and retain foster carers. While carers had opportunities to attend training, the absence of allocated social workers for a significant number of foster carers as well as the inconsistency

in foster carers being reviewed meant that the area was not supporting the skills of foster carers sufficiently. Data provided by the area identified that 18 foster carers had left the service in the previous 12 months. Inspectors were provided with sample exit interviews and found that while this information could inform a retention strategy or plans in relation to support, supervision, training for foster carers, there was no evidence that this was occurring.

Theme 6: Workforce

Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children's services recruit and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.

Summary of inspection findings under Theme 6

Recruitment practices were not robust as there was no system in place to ensure, in line with Children First (2011) and Tusla's recruitment policy, that all staff were vetted by An Garda Síochána. Recruitment and retention of staff was an ongoing challenge, and, while there had been significant recruitment drive and a number of staff appointed to the fostering service, there was an imbalance of experience on some teams.

There were good training opportunities available to the team but supervision required improvement.

Recruitment

Recruitment practices were not robust, were not in keeping with Children First (2011) and were not in line with policy. Inspectors viewed the personnel details of a sample of staff and found that, in general, files contained key information such as references, qualifications and job descriptions. However, of the sample of files reviewed, two did not contain evidence of An Garda Síochána vetting. Not all files contained details of professional registration and a high number of registration certificates on file were expired. One staff file selected by inspectors as part of the sample could not be located.

The absence of a system to ensure all staff were appropriately vetted raised concerns in relation to safeguarding practices, and HIQA escalated this to the interim area manager and sought assurances that vetting was in place for all staff. The area manager stated that an audit would take place and that appropriate safeguards would be implemented if they identified staff who did not have appropriate vetting while vetting was sought.

Recruitment and retention of staff was an ongoing challenge for the service area and a number of vacancies existed within the foster care service. The high turnover and movement of staff within the service meant that 27 social workers and one team leader had been recruited and inducted in the 24 months prior to inspection. As part of this recruitment, a high number of newly qualified social workers had been employed within the service within the last six months.

New staff to the team attended an induction programme. Inspectors reviewed the induction programme agenda and found it was informative, relevant and provided a good foundation of knowledge for new workers. Staff who met with inspectors during interviews and focus groups had a mixed experience of induction to their new roles. While newer social workers had a reduced caseload and met with their supervisors regularly, this was not the experience of all social workers recruited in the 24 months prior to inspection. A probation process was also in place for new staff.

Sufficient staff and skill mix

There were a number of staff vacancies and leave arrangements in place at all levels within the service which meant that their ability to meet the demands of the service was compromised. The impact of this was mainly evident on the fostering team.

While social workers were qualified, there was a number of inexperienced staff. These new staff members were being supported by their colleagues and line managers to develop the skills and experience required. At the time of inspection, a number of these new social workers had not yet taken on full caseloads as was appropriate. This meant that, despite the increase in the number of social workers within the service, they were not yet operating at full capacity.

The service area was in the process of managing a significant period of change at the time of inspection. There were a number of new appointments to senior roles, and the inspection took place in the midst of a campaign to identify a new area manager. A number of team leaders and one principal social worker were in new positions. However, some of these newly appointed staff had no previous experience of managing a team or service and had not received management training.

Supervision and support

All staff received formal supervision but the quality of supervision varied greatly. The frequency of supervision was not always in line with Tusla's policy, and records were not consistently signed by both parties. Inspectors examined a number of supervision records and found that many were detailed, reflective of work undertaken and identified actions to be completed. Case loads as well as individual cases were discussed, and actions to address issues were recorded and prioritised. Staff training and development needs were also recorded as required. However, not all supervision records examined reflected good quality discussions, accountability or support. Many records were vague, did not detail discussions or outline actions agreed, and a high number of files examined showed significant time lapses between supervision sessions with no follow through. Not all newly appointed managers received regular supervision and support in order to ensure that the supervision and support that they were providing was effective.

Caseload management tools had not been consistently implemented. Some supervision records reflected the activity of the social worker, and other teams did not apply the tool. Inspectors raised this issue with the area manager who was not aware that the tool had not been implemented fully within the service.

Staff told inspectors that the quality of supervision and support they received varied. Some social workers described supervision as regular, helpful and supportive while others described supervision as rushed, irregular and often interrupted. Staff identified supports available to them, including peer support, shared learning and informal supervision. For some social workers they were satisfied with the level of support. However, others found their caseloads overwhelming, travel demands isolating and the high turnover of staff as well as the split locations of some teams not conducive to good team work or a supportive environment.

Staff at all levels valued team meetings, in particular the availability of senior managers. The majority of staff who met with inspectors were confident they could voice concerns about the service should they arise.

Principal social workers told inspectors that retention of staff was a priority and that they were implementing a number of strategies to facilitate this. These included closely supervising and supporting new social workers during their induction periods as well as ensuring that all staff received regular support, supervision and training.

Training

Training opportunities were available for all staff, and there was an effective system in place to identify the developmental and training needs of those involved in delivering the foster care service. Inspectors reviewed the regional training needs analysis from 2014, which identified training requirements for the 2015/2016 period and found that it was of good quality, comprehensive and relevant to the needs of children and carers. This needs analysis along with the national workforce learning and development work plan guided the training planning for the area.

Staff members who spoke with inspectors said that access to training had improved in the 24 months prior to inspection. The service returned data to HIQA that indicated that all staff were trained in children first. Information provided during inspection showed that staff training had been provided in a variety of areas, including court room skills, legal training, signs of safety, social work information system training, family mediation, attachment training, mindfulness, reintegration of offenders back into their community and leadership training.

Social workers and team leaders told inspectors that they had also introduced practices to promote shared learning within the service area, which involved social worker presenting training on various topics within team meetings.

Appendix 1 -- Standards and Regulations for Statutory Foster Care Services

<i>National Standards for Foster Care (April 2003)</i>
Theme 1: Child-centred Services
<p>Standard 1: Positive sense of identity Children and young people are provided with foster care services that promote a positive sense of identity for them.</p>
<p>Standard 2: Family and friends Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.</p>
<p>Standard 3: Children’s Rights Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and have their views, including complaints, heard when decisions are made which affect them or the care they receive.</p>
<p>Standard 4: Valuing diversity Children and young people are provided with foster care services that take account of their age, stage of development, individual assessed needs, illness or disability, gender, family background, culture and ethnicity (including membership of the Traveller community), religion and sexual identity.</p> <p><i>Child Care (Placement of Children in Foster Care) Regulations, 1995 Part III Article 8 Religion</i></p>
<p>Standard 25: Representations and complaints Health boards[¥] have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.</p>

[¥] Where reference is made to Health Boards these services are now provided by the Child and Family Agency.

National Standards for Foster Care (April 2003)

Theme 2: Safe and Effective Services

Standard 5: The child and family social worker

There is a designated social worker for each child and young person in foster care.

*Child Care (Placement of Children in Foster Care) Regulations, 1995
Part IV, Article 17(1) Supervision and visiting of children*

Standard 6: Assessment of children and young people

An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

*Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 6: Assessment of circumstances of child*

Standard 7: Care planning and review

Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

*Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 11: Care plans
Part IV, Article 18: Review of cases
Part IV, Article 19: Special review*

Standard 8: Matching carers with children and young people

Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

*Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 7: Capacity of foster parents to meet the needs of child*

*Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 7: Assessment of circumstances of the child*

National Standards for Foster Care (April 2003)

Standard 9: A safe and positive environment

Foster carers' homes provide a safe, healthy and nurturing environment for the children or young people.

Standard 10: Safeguarding and child protection

Children and young people in foster care are protected from abuse and neglect.

Standard 13: Preparation for leaving care and adult life

Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

Standard 14a: Assessment and approval of non-relative foster carers

Foster care applicants participate in a comprehensive assessment of their ability to carry out the fostering task and are formally approved by the health board³ prior to any child or young person being placed with them.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 5 Assessment of foster parents
Part III, Article 9 Contract

14b. Assessment and approval of relative foster carers

Relatives who apply, or are requested to apply, to care for a child or young person under Section 36 (1)(d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board.

Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 5 Assessment of relatives
Part III, Article 9 Contract

³ Formally known as Health Boards at time of writing Standards, now known as The Child and Family Agency.

National Standards for Foster Care (April 2003)

Standard 15: Supervision and support

Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.

Standard 16: Training

Foster carers participate in the training necessary to equip them with the skills and knowledge required to provide high-quality care.

Standard 17: Reviews of foster carers

Foster carers participate in regular reviews of their continuing capacity to provide high quality care and to assist with the identification of gaps in the fostering service.

Standard 22: Special Foster care

Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.

Theme 3: Health and Development

Standard 11: Health and development

The health and developmental needs of children and young people in foster care are assessed and met. They are given information, guidance and support to make appropriate choices in relation to their health and development.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 6 Assessment of circumstances of child
Part IV, Article 16 (2)(d) Duties of foster parents

Standard 12: Education

The educational needs of children and young people in foster care are given high priority and they are encouraged to attain their full potential. Education is understood to include the development of social and life skills.

Theme 4: Leadership, Governance and Management

Standard 18: Effective policies

Health boards have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 5(1) Assessment of foster carers

Standard 19: Management and monitoring of foster care agency

Health boards have effective structures in place for the management and monitoring of foster care services.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part IV, Article 12 Maintenance of register
Part IV, Article 17 Supervision and visiting of children

Standard 23: The Foster Care Committee

Health boards have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice.

*Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 5(3) Assessment of foster carers*

*Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 5(2) Assessment of relatives*

Standard 24: Placement of children through non-statutory agencies

Health boards placing children or young people with a foster carer through a non-statutory agency are responsible for satisfying themselves that the statutory requirements are met and that the children or young people receive a high quality service.

*Child Care (Placement of Children in Foster Care) Regulations, 1995
Part VI, Article 24: Arrangements with voluntary bodies and other persons*

Theme 5: Use of Resources**Standard 21: Recruitment and retention of an appropriate range of foster carers**

Health boards are actively involved in recruiting and retaining an appropriate range of foster carers to meet the diverse needs of the children and young people in their care.

Theme 6: Workforce**Standard 20: Training and Qualifications**

Health boards ensure that the staff employed to work with children and young people, their families and foster carers are professionally qualified and suitably trained.