Health Information and Quality Authority
Regulation Directorate

Monitoring Inspection Report - Non-statutory Foster Care Services under the Child Care Act 1991 (as amended)

Name of Agency:	Care Visions Fostering Service	
Dates of inspection:	8 – 10 November 2016	
No. of Fieldwork days:	3	
Lead inspector:	Una Coloe	
Support inspector(s):	Bronagh Gibson Sharron Austin Niamh Greevy	
Type of inspection:	☒ **Announced** ☐ **Unannounced** ☒ **Full** ☐ **Themed**	
Inspection ID:	**0018173**	

About monitoring

The purpose of monitoring is to safeguard vulnerable children of any age who are receiving foster care services. 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 lives.

The Health Information and Quality Authority (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 services taking care of a child on behalf of the Child and Family Agency (Tusla) including non-statutory providers of foster care.

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

- **Assess** if the service provider has all the elements in place to safeguard children and young people and promote their well being while placed with their service
- **Seek assurances** from service providers that they are **safeguarding children** through the mitigation of 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 the HIQA's findings.

Monitoring inspections assess continuing compliance with the regulations and Standards, 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	☒
Theme 2: Safe and Effective Services	☒
Theme 3: Health and Development	☒
Theme 4: Leadership, Governance and Management	☒
Theme 5: Use of Resources	☒
Theme 6: Workforce	☒

1. Methodology

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

During the 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 inter-agency and multi-disciplinary work
- outcomes for children

The key activities of this inspection involved:

- the interrogation of data
- reviewing of policies and procedures
- reviewing of 20 children's case files
- the review of 24 foster carer's files
- meeting with 4 children and 12 carers
- meeting with 2 link workers
- interview with the managing director
- interview with the principal social worker
- interview with the recruitment and placement officer
- interview with the placement support worker
- telephone interviews with 7 Tusla social workers
- telephone interviews with 3 external professionals including Guardians ad Litem
- visiting 5 foster care homes
- telephone interviews with 3 parents
- reviewing completed external questionnaires from Tusla social workers and other external professionals

Acknowledgements

HIQA wishes to thank the children and carers, for the openness with which they embraced the inspection process and welcomed inspectors into their homes. Inspectors also wish to acknowledge the cooperation of the members of Care Visions Fostering Service with the inspection.

2. Profile

2.1 The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State Agency – the Child and Family Agency - overseen by the Department of Children and Youth Affairs. The Child and Family Agency Act 2013 (No. 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency have responsibility for a range of services, including the provision of a range of care placements for children including statutory foster care services.

Children's foster care services may also be provided by non-statutory foster care agencies following agreement with the Child and Family Agency. The Child and Family Agency retain their statutory responsibilities to children placed with these services and approve the foster carers through their foster care committees. The foster care agency is required to adhere with relevant Standards and regulations when providing a service on behalf of the Child and Family Agency. Both services are accountable for the care and well-being of children. This inspection focuses on the specific responsibilities of the service provider under the Standards in providing quality and safe care to children.

2.2 The Service Provider

Care Visions fostering service has been in operation in Ireland since 2013 and is available to provide foster care placements to a range of Tusla service areas. It provided placements for children including short term, long term, respite and general foster care placements.

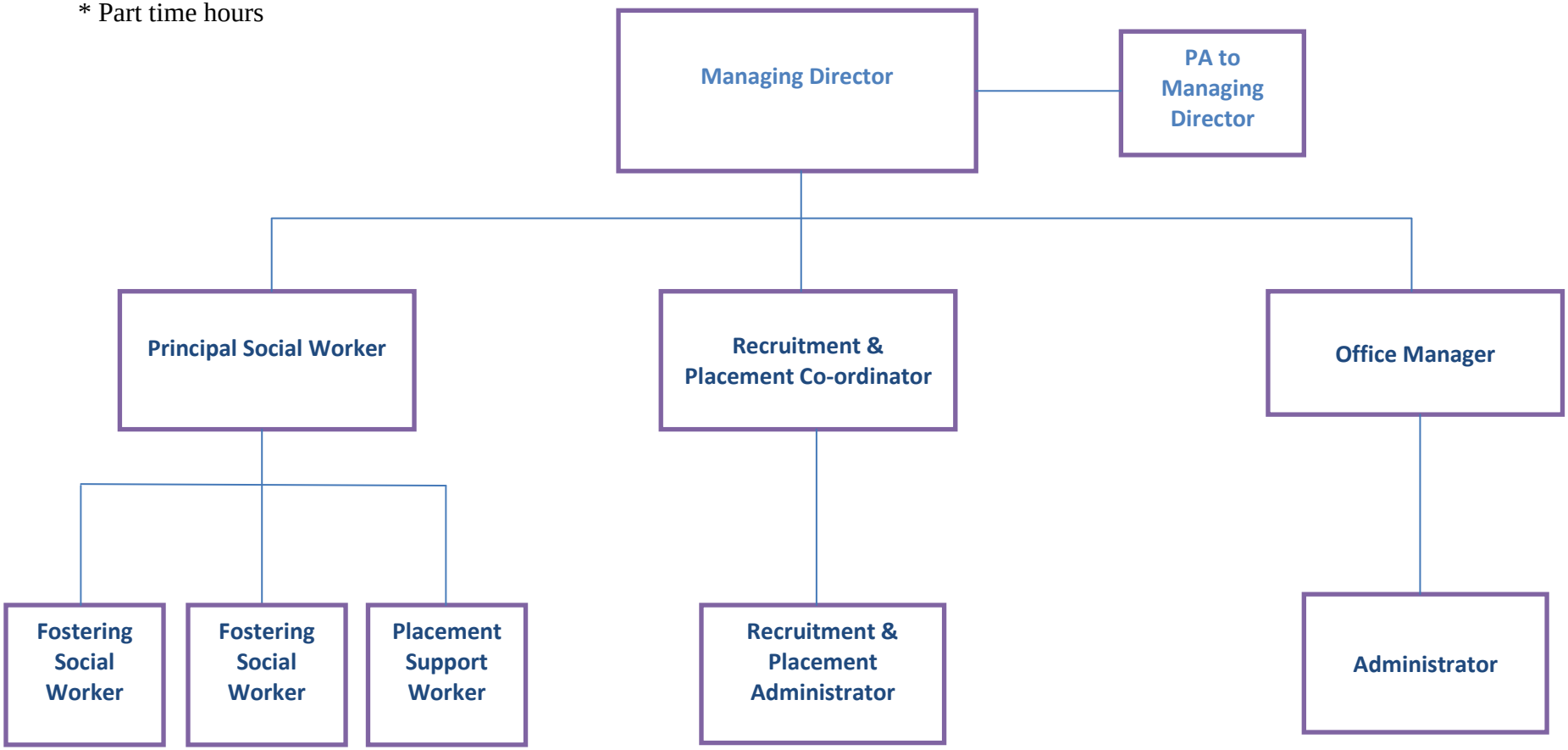
The foster care service comprised of a managing director who was supported in her role by a principal social worker. Information provided to HIQA by Care Visions outlined that the service also had a recruitment and placement manager, an office manager, two fostering link workers, a support worker and two administrators.

The service operated out of an office in county Kildare. At the time of the inspection, the service had 27 foster care households across the country that provided foster care placements for 26 children. Care Visions fostering service had individual agreements for each placement with Tusla but there was no service level agreement in place.

The organisational chart in Figure 1 on the following page describes the management and team structure as provided by the area.

Figure 1: Organisational structure of the foster care agency[1]

* Part time hours



[1] Provided by the Foster Care Agency

3. Summary of Findings

Children in foster care require a high quality service, which is safe and well supported by social work practice. Foster carers must be able to provide children with warm and nurturing relationships in order for children to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

Care Visions fostering service is a 'for profit' organisation and its services are monitored by the Child and Family Agency.

In this inspection, HIQA found that of the 20 Standards assessed, the service

- met 3 Standards,

- required improvement in 16 Standards while

- significant risks were identified in 1 Standard.

The findings are set out in Section 5 of this report and the action plan is published separately.

Children were cared for in safe and appropriate homes provided by Care Visions foster carers and they had their physical and emotional needs met. Care Visions staff were dedicated and committed to the service and demonstrated a good knowledge of children's needs. Foster carers were respectful and caring in their interactions with children. Foster carers were supported in their role but this needed to be enhanced especially when foster carers were experiencing difficulties in placements or in the management of behaviours that challenged.

Care Visions staff and foster carers were respectful of children and whilst some attempts were made to ensure there was a child centred approach, improvements were required to promote children's rights and to ensure their participation. Children had contact with their families but this was not actively facilitated by all foster carers in their home. The oversight of complaints made about the service was not sufficient.

Governance structures were recently changed and some members of the management team were recently recruited. Although, inspectors found that there was good leadership provided to the staff team, management systems required further development and improvement to ensure the service was safe and effective.

The management of risk was not sufficient and deficits were identified in safeguarding practices. There were child protection and welfare concerns which had not been managed in line with Children First: National Guidance for the Protection and Welfare of Children (2011).

The recording, reporting and oversight of incidents and significant events was not adequate and systems required improvement.

Overall, Care Visions fostering service were committed to providing and delivering a high quality, safe service but management and monitoring systems required significant improvement to ensure this could be achieved. The number and types of placements for children were limited and there were plans to grow the service further both in relation to the recruitment of staff and additional foster carers. This would assist the quality of service for children by ensuring appropriate placements were available for children in their local area with access to respite placements, as required. The service had comprehensive plans to develop the service through quality improvement initiatives and through a business plan.

This report makes a number of findings which the provider is required to address in an action plan. The provider's action plan is published separately to this report.

4. Summary of judgments under each Standard

During the inspection, inspectors made judgments against the National Standards[2]. They used four descriptors:

Exceeds Standard – services are proactive and ambitious for children and there are examples of excellent practice supported by robust 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.

National Standards for Foster Care (April 2003)	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 8: Matching carers with children and young people	Requires Improvement
Standard 9: A safe and positive environment	Meets standard
Standard 10: Safeguarding and child protection	Significant risk identified
Standard 13: Preparation for leaving care and adult life	Meets standard
Standard 14: Assessment and approval of foster carers	Requires Improvement
Standard 15: Supervision and support	Requires Improvement

[2] Please refer to Appendix 1 for full description on National Standards for Foster Care (April 2003) and Child Care (Placement of Children in Foster Care) Regulations, 1995

Standard 16: Training	Requires Improvement
Standard 17: Reviews of foster carers	Requires Improvement
Standard 22: Special Foster care	Not applicable
Theme 3: Health and Development	
Standard 11: Health and development	Requires Improvement
Standard 12: Education	Meets standard
Theme 4: Leadership, Governance & Management	
Standard 18: Effective policies	Requires Improvement
Standard 19: Management and monitoring of foster care agency	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	Requires Improvement

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.

Inspection findings

Care Visions fostering service was respectful of children and whilst efforts were made to ensure there was a child centred approach, improvements were required. Children's rights were promoted through supports provided to the foster carers but direct work with children was limited. The service valued the views of children but systems to encourage children to participate and be involved in decision making were in the early stages of development. Children had contact with their families but this was not actively facilitated by all foster carers in the foster care home. Oversight of complaints made about the service was not sufficient.

Children's Rights

Children's rights were valued by the service but additional work was required to ensure records on children's files reflected the promotion of these rights. On admission to the foster care service, children received a memory box which contained information relating to their rights and independent advocacy service. Inspectors found that there was no child friendly information available in relation to the foster care service or the national standards. This was confirmed through interview and information provided to HIQA prior to the inspection. The Care Visions principal social worker told inspectors that this information was being developed at the time of the inspection.

Fostering link workers met with children while visiting their foster carers and reflected these interactions in records which were reviewed by inspectors. The support worker employed by the service explained to inspectors that through her direct work with foster carers, she encouraged them to explain rights to children and advocate on the child's behalf. This was confirmed by foster carers during home

visits. External professionals were satisfied that children's rights were promoted through a multidisciplinary approach between professionals and the fostering service at various meetings.

All children had an allocated Tusla social worker and a guardian ad Litem was appointed, where appropriate. Efforts had been made to link children with an independent advocacy service. Inspectors reviewed documentation which showed the service made attempts to include independent advocates in their events for foster carers and children. The support worker explained to inspectors that the service would continue to include independent advocates in their day to day work.

The quality of children's files required improvement to ensure they clearly reflected aspects of work completed with or on behalf of the children in relation to rights. Inspectors reviewed records to examine how children's rights were being promoted. This was well recorded on some files. For example, link workers explained children's rights to foster carers and encouraged them to ensure children had choices and that their views were heard. Although link workers told inspectors that they carried out this work with all foster carers, this was not evident in all files reviewed.

The Care Visions principal social worker told inspectors that they had not received a request from a child or a foster carer to view their records. This was confirmed by a fostering link worker. Some foster carers did not know how to access their information and a link worker told inspectors that carers needed to request their information formally in writing. The Care Visions principal social worker told inspectors that a policy on access to information had not been developed.

Diversity

The service was meeting the needs of some children in relation to diversity, disability, communication and literacy but this required improvement. There was a policy to guide the team on anti-discriminatory practice. This included details on promoting equality in relation to gender, race, religion, and disability. According to data returned to HIQA by Care Visions fostering service, 34% of the children placed with the service were from a diverse ethnic, cultural or religious background and 11% had a disability. Children were not always placed with carers from a similar background. Link workers interviewed as part of the inspection were aware of best practice approaches and outlined that although they considered diversity and culture during the matching process, there were insufficient carers from a variety of backgrounds to ensure that children were placed with families of a similar background.

Inspectors found that children's cultural and diverse needs had been considered in some cases with clear actions relating to culture and religion. There was evidence of discussions regarding children's attendance at religious ceremonies and foster carers learning about children's cultural backgrounds. In some circumstances, there were clear examples of the views of parents in relation to their children's upbringing and that these were adhered to by foster carers. However, the service did not always demonstrate how children were supported to maintain their cultural identity. For example, there were children from central Europe who's religious and dietary preferences were not fully explored.

The service could not provide foster care placements with foster carers from the same cultural background as some of the children. Considering this lack of capacity within the service, supplementary training on cultural diversity was not provided by the service for carers.

The service met the needs of some children with a disability. Inspectors found that there was collaborative working between the service and Tusla social work departments in relation to meeting the needs of children with a disability. This was confirmed to inspectors by social workers. Inspectors reviewed a number of files of children with various learning disabilities. It was evident that some children had been referred to disability services but there were some delays in accessing such services. A foster carer told inspectors that there were significant delays accessing such a service which was confirmed by a guardian ad litem. Inspectors found that link workers had discussed children's needs in supervision sessions with foster carers and it was evident from some files reviewed that children with a disability had the appropriate supports in schools such as a special needs assistant. In addition, inspectors observed visual aids and schedules for children who required them during home visits. However, there was limited information on other files to evidence how the needs of the children with a disability were met. A review of foster carer files found that some carers who cared for children with a disability had not received training in this area.

Communication

Communication with children and families was effective within the service and supplementary methods to communicate and ensure participation of children was in the process of being developed. Inspectors observed foster carers interacting and communicating with children in a positive manner during home visits.

Link worker case notes provided some evidence of good communication with children and foster families. Foster carers told inspectors that they were happy with the level of contact with the service. Inspectors observed a team meeting where

support groups for foster carers were discussed. This was in the early stages of development, as was an online tool for foster carers to communicate with and support each other. There were good arrangements in place to monitor online communication by the service.

There was some information provided to children when they were first placed in the service but this was not adequate as it did not provide children with sufficient information about the Care Visions service. This was acknowledged by service managers and they told inspectors that they were in the early stages of improving information for children. In addition, the service was in the early stages of setting up a support group for foster carers' children to encourage participation and involvement in decision making but this type of group had not been considered for the children who were placed in foster care. The service had recently facilitated a fun day for the children and the intention was to facilitate more opportunities of this nature to meet and consult with children.

Each child was allocated a Tusla social worker who visited them from time to time. Visits were also made to foster care placements by Care Visions link workers. Link workers recorded these visits which were opportune times to check in with children and seek their views on the service. However, this practice was not demonstrated in link worker records. The principal social worker acknowledged the informal arrangements within the service to consult and communicate with children and that this was not structured or formalised. She explained that it was the services intention to meet with all of the children who use the service to seek their views in the near future.

A number of external professionals reported that Care Visions contributed to reports in relation to the views of children and they said that there was good communication between the service and external professionals on an ongoing basis. They reported that children had choice in their daily lives regarding meal, activities and family contact. Foster carers told inspectors that they made every effort to present children's views at the time of child in care reviews and when decisions were being made about children's day to day care.

Family and Friends

The service recognised the importance of children maintaining positive relationships with their parents, siblings and significant others. However, the service did not proactively encourage foster carers to facilitate family access within the foster care home. This was not in keeping with the national standards.

Children's access with their birth family was set out in individual care plans. Foster carers told inspectors that they were aware of access arrangements for the children in their care. Contracts between foster carers and Care Visions stipulated that foster carers had to keep the service informed about family contact. However, some social workers told inspectors that these arrangements were changed by foster carers without the consent of the allocated social worker. There was no policy or procedure for the service in relation to the provision of family access. It was acknowledged by the principal social worker and managing director that some carers would not facilitate access between children and their birth families in the foster care home.

Care Visions had two sibling groups placed together at the time of the inspection and this was in line with their care plan. Every effort was made by the service to support these placements. Social workers told inspectors that they were satisfied with the level of care these children were receiving. There were examples of unsuccessful sibling placements but it was clear from records that placing these children together was not meeting their individual needs.

It was not always possible for the service to provide a placement for children within their own community. Information provided to HIQA prior to the inspection outlined that 61% of children were placed outside of their community. The managing director and principal social worker acknowledged that this was not ideal. However, significant efforts had been made by the foster carers and the allocated social worker to minimise the disruptions. For example, Care Visions and Tusla worked together to provide transport to school for some children so that they continue attending their local school.

The service did not demonstrate how or when it communicated with children's birth families. However, birth parents who spoke with inspectors said that there were well informed about their children's care by the allocated Tusla social worker. Information on children's files did not contain contact details for each child's birth family. This limited the services opportunity to contact a parent in the event, for example, of an emergency.

Complaints

There was a system in place for the investigation and management of complaints but this was not adequate. Inspectors found that there was a policy to guide practice in this area and a complaints officer was identified for the service. Link workers interviewed by inspectors were aware of the complaints procedure and supported foster carers if they wished to make a complaint. Sufficient information was provided to foster carers in relation to complaints but one foster carer told inspectors that they were not aware of the complaints procedure. The complaints

procedure for children was not child friendly and was not updated to reflect Tusla as the statutory agency for children in care. It did not record the name of the complaints officer for the service. This was acknowledged by the managing director and she outlined that there were plans to address these deficits.

There was an adequate system in place to record and manage complaints made to the service. Inspectors reviewed the service complaints log and found that there were two complaints made since the establishment of the service in 2013. On review, inspectors found that there were no complaints made by children about the quality of the service they received. Complaints reviewed by inspectors were found to be managed appropriately and in a timely way. Recording of complaints required improvement as the complaints log did not record who received the complaint or if the complainant was satisfied with the outcome of an investigation.

Information provided by a number of external professional's referenced dissatisfaction with the service in the past including concerns in relation to supports offered to foster carers and timeliness of actions taken by the service. External professionals said they were dissatisfied at times in relation to how these issues were addressed by Care Visions. Inspectors found that these complaints were not recorded by the service.

Theme 2: Safe and Effective Services

Services promotes 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.

Inspection findings

Children's physical and emotional needs were met and they were cared for by assessed and approved foster carers. There were some systems in place to match children with appropriate foster carers but they were not transparent. Documents such as care plans were not always evident on children's files and information provided to foster carers in advance of a placement was not always adequate. The monitoring and oversight of child protection and welfare concerns and allegations was not sufficient and there were significant gaps in the management and recording of child protection concerns. Foster carers were supported in there their role but additional efforts were required when foster carers were experiencing difficulties in placements or in the management of behaviours that challenged.

Assessment and Care Planning

All children lived in homes with approved foster carers and each child had an allocated Tusla social worker. Care Visions fostering service had some systems in place to consider the needs of children whilst identifying a potential foster care placement for them. There was a placement matching policy in place. Although staff were able to describe the matching process, it was not consistently documented on a case by case basis and therefore not transparent. The recruitment and placement officer explained to inspectors that an initial placement request form was completed by the relevant social work department and a potential match was identified in consultation with Care Visions principal social worker. This process was carried out on an informal basis and not recorded. The social work department were then required to submit a referral form for the child. Following receipt of this, a pre-placement meeting took place with the identified foster carer, link worker, principal social worker and a representative from Tusla. Inspectors found that although there

was some evidence of the matching considerations, the quality of information required by Care Visions at referral stage was not always sufficient and did not support this process. Inspectors observed a placement meeting where referrals to the service were discussed and it was evident that staff had detailed knowledge about potential carers. Formal records were not kept in relation to these meetings. Some foster carers said that they provided emergency placements on occasion and due to the nature of these placements, adequate consideration was not always given regarding the needs of the child.

Statutory care planning and review processes were in place and adhered to for each child. This was the responsibility of Tusla social workers. Copies of care plans and minutes of child in care reviews were on file for some children. There was evidence that link workers contributed to the care planning and review processes. Records showed that recent admissions to the service did not have an up to date care plan on file. A link worker told inspectors that requests were made to social workers for these documents but there were delays. The principal social worker confirmed that care plans were not a requirement at the time of referral. This meant that the needs of children could not be fully considered within the matching process. This deficit was identified during file audits carried out by the service but improvements were not subsequently made.

Placement plans were not in place for each child. The managing director described placement agreements between the service and foster carers as placement plans. Inspectors reviewed a sample of these and found that they did not constitute a placement plan. As a result, it was not possible for Care Visions to measure progress within placements and to ensure foster carers consistently met the needs of all children as stipulated in their care plan.

Information provided to foster carers by Care Visions prior to a child being placed was not always adequate. There were some systems in place to share information between Tusla the service and foster carers prior to the commencement of a placement, but some foster carers said this was not always sufficient. For example, some foster carers said they were not aware of the learning ability of the child placed with them. Inspectors found from a review of files that there was insufficient detail contained within the files to outline the type of information provided to foster carers prior to the placement.

The service did not carry out reviews in relation to unplanned placement endings. Information returned by Care Visions to HIQA showed that in the 12 months prior to the inspection, 3 placements had ended in an unplanned way. The principal social worker told inspectors that meetings were held with the placing social work department following a placement breakdown. Inspectors found that this did not

constitute a review and this limited the service capacity to learn from unplanned endings. Inspectors found evidence in link worker case notes where carers were advised by Care Visions staff to end a placement due to their challenging nature. This was brought to the attention of Care Visions principal social worker who acknowledged that this was not good practice and she acknowledged that these are decisions which should be made at child in care reviews with input from all professionals involved.

Children with complex needs did not always receive the required supports in a timely manner. Information provided to HIQA indicated that there were 12 children waiting for specialist supports. Specialist supports such as mental health services and speech and language are provided by Tusla and/or Health Service Executive. Records showed that there were some delays in accessing these supports. The managing director told inspectors that as the service expanded, Care Visions may be in a position to provide some specialist supports but these plans were not fully developed at the time of the inspection.

Quality of Care

Inspectors found that children received good quality care in their foster homes. Homes visited by inspectors were found to be warm, comfortable and free from any obvious hazards. Foster carers were observed as nurturing and respectful towards the children. Children presented as content, were appropriately dressed and showed inspectors their toys and games. Records showed that some children were brought on holidays with their foster care family. Social workers told inspectors that they were satisfied that children had opportunities to engage in hobbies and leisure activities of interest to them and they were happy with the quality of care provided. Foster carers told inspectors that they arranged various after school activities for children to help them develop and sustain friendships.

Respectful and appropriate interactions between foster carers and children were observed during home visits by inspectors. Some external professionals queried the emotional care provided to some children by foster carers and the quality of their relationships with the children placed with them. Although Care Visions staff and external professionals said they were working collaboratively to support these placements, direct work with foster carers was not well recorded to reflect how these issues were managed.

Records in relation to children showed that all of the children placed in Care Visions were under the age of 16. This meant that they did not require direct work in relation to preparing to leave care. In the event that the service did have a child that required this work, there was a transition into adulthood policy in place. This

contained detailed information for foster carers in relation to supporting young people enter into young adulthood. Foster carers told inspectors that they were interested in learning about leaving and aftercare so that they could be prepared to support children over the age of 16.

Safeguarding and Child Protection

There were some measures in place to safeguard and protect children from abuse but significant improvements were required in this area. There was a designated liaison person for the service and staff members had a good understanding of safe care practices. There was a safeguarding and child protection policy which was in compliance with Children's First (2011). Each foster care household had a designated link worker and they presented with a good understanding about how to keep children safe. External professionals outlined that they supported the Care Visions fostering team to manage concerns if they arose.

Information returned to HIQA reported that there had been no child protection or welfare concerns reported by the service in the 12 months prior to inspection. The service maintained a log of all child protection concerns and this showed that there were two child protection concerns reported by the service up to December 2014. Following examination of these, inspectors found that both concerns were well managed but it was difficult to determine the safeguarding measures put in place as records were not well maintained.

Inspectors reviewed various records in relation to children and foster carers over the course of the inspection. These included significant event notifications and case notes. On review, inspectors found that there were four concerns of a child protection nature detailed in significant event notifications, but child protection reports were not made to the relevant social work department. This was brought to the attention of the principal social worker and the managing director at the time of the inspection, and inspectors were assured that no children were at ongoing risk as a result. Records related to these events did not contain safety plans for children and indicated a significant time delay in updating risk assessments. Risk assessments examined by inspectors were not always of good quality.

Data provided by Care Visions to HIQA indicated that there were no allegations against foster carers or children in foster care prior to the inspection. However, over the course of the inspection, inspectors found six separate child protection concerns related to allegations, for example, against foster carers, children in foster care and other adults. None of these child protection concerns were recorded in the service child protection log. Details of these concerns were found in foster carer's and children's files. Records showed that in some instances there were delays in

concerns being reported to the service by a foster carer, protective measures taken in relation to children involved were not demonstrated on centre files, and records of concerns were not always held on both the foster carer's and the children's case files. Inspectors sought further information from the principal social worker and the managing director in relation to all of these concerns and were assured that no child was currently at risk. The principal social worker confirmed that the relevant social work departments were aware of these concerns either through notifications from Care Visions or because allegations were made directly to Tusla. However, an investigation was not carried out in relation to one allegation. Inspectors brought this to the attention of the relevant Tusla Area Manager and Care Visions. HIQA was provided with assurances in relation to the protective measures taken in this case and that an investigation would be carried out promptly by social workers.

The managing director acknowledged that day to day practice in relation to identifying, categorising and managing concerns about children required significant improvement, and she explained that this had prompted the service to recruit a principal social worker in August 2016. The principal social worker was the designated liaison person and had good knowledge and experience of managing child protection and welfare issues. The principal social worker was in the process of bringing about improvements in this area. Inspectors found that there were improvements in the management of risk to children by the service but there was a need to ensure systems of reporting and categorising child protection concerns were robust and that there was managerial oversight of all records held in the service to ensure all concerns were reported in a timely and appropriate way. Despite awareness by managers of deficiencies in reporting and managing concerns about children prior to the appointment of the principal social worker, inspectors were not informed of the measures the service was taking to ensure there were no outstanding concerns about children in the service.

The service had a system in place to record and report significant events. They maintained a register of all significant events and this provided oversight for managers. However, it was acknowledged by the principal social worker that some incidents were incorrectly categorised as a significant event and she was in the process of improving practice in this regard. Significant events reviewed by inspectors were found to be reported to all relevant parties. Recording of significant events was not adequate. Incidents were not categorised accurately such as damage to property or self injurious behaviour. This meant that the type of incident involved could not be determined from the outset. In addition, the significant event log was not cross referenced with other related documents. This made it difficult for the service to track and manage all records related to individual events.

The service had a policy in relation to children missing from care and staff were aware of the national policy. Foster carers were able to explain to inspectors their responsibility to report a child missing from their care. The principal social worker informed inspectors that there was a protocol in place between the service and Tusla. She explained that if a child went missing from care during office hours, this would be reported to the children's social worker. Outside of office hours, foster carers reported children missing from care to Care Visions. Information returned to HIQA reported that there had been five occasions in the 12 months prior to the inspection where a child had gone missing from their placement. It was evident from records reviewed that foster carers reported children as missing to the relevant authority. Records recorded that foster carers were well supported by Care Visions staff in this regard. However, there were no absence management plans on files for children who showed a pattern of being missing from care.

Staff members were aware of protected disclosures and there was a policy in place for the service in relation to this. The service had a safe care good practice guide which was completed with the foster carers when a child was placed with them. This was a generic document which outlined expectations in relation to rules, personal space and sanctions. However, other safeguarding measures in the service were not robust. Foster carers who had transferred from another service did not have updated placement agreements and due diligence had not occurred. Garda vetting was not in place for all of the staff prior to commencing work in the service. Foster carers had completed aspects of safeguarding and child protection training through their initial training programme but training in Children First (2011) had not been provided to staff or foster carers. The principal social worker told inspectors that this had been scheduled and this was reflected on the training plan reviewed by inspectors.

Foster Carers - Assessment Training and Support

All foster carers within the service were assessed and approved. No child was placed with an unapproved carer. There was a policy in place on the assessment of foster carers which outlined the various steps in the process but this needed to be updated to reflect the establishment of Tusla. Inspectors reviewed documentation provided to potential foster carers about the service and fostering and this was found to be detailed and informative.

There was a recruitment and placement officer for the service and they explained that they had responsibility to manage timeframes of the recruitment of foster carers, from initial enquiry to approval stage. According to data returned to HIQA prior to the inspection, the service had received 1455 new enquiries to foster over the previous 12 months and of these, 10 foster carers had been approved. Potential applicants who contacted the service were screened by the administration team. The

recruitment and placement officer had responsibility to conduct a home visit and following consultation with the principal social worker, the candidate, if deemed suitable, was put forward for a foster care assessment.

Inspectors reviewed a sample of assessments and found that the timeframes for completion ranged from three to six months. The timeframe for the approval of the assessment by the relevant foster care committee, once the assessment had been signed off by the principal social worker was between one and seven months. Inspectors observed a meeting where the assessment process was reviewed and it was outlined that the average time for fostering assessments was between 16 and 24 weeks. This, at times, exceeded the timeframe recommended by the national standards. Additional delays were evident in presenting the assessments of potential foster carers to foster care committees. The recruitment and placement manager said that foster care committees on occasion had capacity to take one referral per sitting which delayed other assessments being put forward. There was a comprehensive recording tool in place to outline each stage of the recruitment and assessment process which documented if there were delays of any nature and the reasons for same.

Assessments of foster carers varied in quality. Assessments were carried out by independent social workers contracted by Care Visions. Their work was overseen by the principal social worker. Assessments examined by inspectors were found to be detailed but lacked dept in relation to some issues. This was identified by the principal social worker and she had escalated her concerns to the managing director shortly after her appointment. The principal social worker explained that there was a drive to improve the quality of these assessments. Supervision records for independent assessors showed that the principal social worker had begun to address the quality of assessments. The principal social worker told inspectors that she had supplemented current assessments with further interviews and visits to potential foster carers. Foster carers told inspectors that they were satisfied with the assessment process, found it to be thorough and had opportunities to discuss aspects of the assessment report if discrepancies arose.

Inspectors found from a review of foster care files that the necessary checks of foster carers were carried out including Garda Vetting, health and safety checks, medical checks and verification of references. Garda vetting disclosures for other adults who were living in foster care homes or who had significant contact with children were also evident on files reviewed. A contract was in place for each foster care placement. It set out expectations in relation to the provision of the service to individual children. However, it was not clearly articulated in contracts that foster carers were to facilitate family access in the foster care home as per the national standards. This gap was acknowledged by the managing director.

Reviews of all foster carers were not carried out in line with regulations and standards. Regulations stipulate that reviews of foster carers should be carried out after one year of fostering but these had not been carried out for all foster carers. This deficiency was acknowledged by managers and plans were in place to address this backlog. Recording of annual reviews examined by inspectors required improvement. For example, although inspectors found some indication in records that a review had taken place, they were not well documented and review reports were not on file. All foster carers should be reviewed for their ongoing suitability on a three yearly basis. However, as the fostering service was not yet three years in operation, these reviews had not begun.

The standards require that following a serious incident or an allegation, foster carers are reviewed for their ongoing suitability as safe carers. Inspectors examined records in relation to reviews of three different sets of foster carers following an allegation. One review was delayed by one year and although there were no risks in relation to children, this was not timely or adequate. The principal social worker had identified deficits with the quality of this review and it was put on hold for further review by her. This meant an additional delay. Allegations against two other sets of foster carers were under investigation at the time of the inspection, and as such, a review of these foster carers had not yet begun. As reviews following unplanned placement endings had not happened, the service was unable to identify any issues related to the quality of care provided by foster carers which might result in a review of their ongoing suitability.

The service had some supports in place for foster carers and children with complex behaviours. Foster carers told inspectors that staff were always accessible to give support when required. In addition, there was an out of hours service to provide supports to foster carers outside of normal working hours including evenings and weekends. This included phone support or in some cases, a home visit was facilitated. A member of the Care Visions team was recently trained to provide training to all approved foster carers in the management of behaviour that challenged, and there was a plan in place to roll this out to all foster carers in 2017. From a review of supervision records, inspectors found that behaviours that challenged were discussed between link workers and foster carers. Link workers told inspectors that supervision was a supportive mechanism for foster carers in this regard. Link workers told inspectors that they liaised with Tusla social workers to acquire additional supports for children on behalf of the foster carers involved.

Inspectors found that some children had comprehensive plans in place in relation to managing their behaviour. These were found to be developed collaboratively between the fostering service, Tusla and the child. Inspectors found that these placements benefited from having these plans in place. Inspectors also found that

external consultants were brought in to support placements from time to time and that this was a good support for foster carers. Link workers told inspectors that they provided additional supports to foster carers who were managing complex behaviours and that they increased their visits to these placements. However, these additional supports were not well recorded. Inspectors reviewed some cases where placements had ended or were about to end due to various challenges. The quality of records in these cases was poor and did not demonstrate fully, how these foster carers were supported to sustain these placements. External professionals told inspectors that they were not satisfied that supports to some foster carers currently managing complex behaviours were timely or sufficient.

Foster carers were routinely allocated a fostering link worker and received regular support and supervision. Records showed that supervision was provided consistently and this was valued by foster carers. Foster carers interviewed a part of the inspection were satisfied with the level of support by their link workers. Some foster carers said that they had experienced three changes to her link worker in a relatively short space of time. However, inspectors found that these were necessary changes due to link workers leaving the service and others being recruited.

There was a training plan in place for foster carers and all carers had to complete basic training in relation to fostering in advance of an assessment taking place. The service provided training in core areas which included safe care practice, child protection and building attachments in the first year of fostering. Contracts with foster carers outlined their requirement to attend this training. Although there was a training plan in place for foster carers, there were delays in providing core training. All carers were also expected to attend training in Children First (2011) and training in relation to managing behaviours that challenged. Not all foster carers had received this training but it was scheduled. Carers told inspectors that they were happy with the training provided but expressed a need for further training in managing behaviours. Training records showed that some carers had received some additional training in relation to children going missing from care and first aid but this was not provided or scheduled for all. In addition, training had not been provided to foster carers in diversity or the promotion of rights.

Care Visions provided respite care to support children's placements but this aspect of the service was not sufficiently resourced. A maximum of 10 days respite care per year was offered to foster carers. This was an acknowledgment of the challenges faced by some foster carers and was a supportive mechanism. Inspectors found that respite placements were not always provided when required. Managers, staff and social workers told inspectors that there were not enough foster carers within the service to ensure each child had a respite placement when required. As there was no

national service level agreement in place with Tusla, expectations of Care Visions to provide this aspect of the service were not established.

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.

Inspection findings

Children's health needs were met but comprehensive medical records were not consistently maintained by the service. Education was highly regarded by the service and all children attended school on a full time basis.

Health Needs

Children's health needs were promoted and healthy lifestyles were encouraged but comprehensive medical records were not consistently maintained. Foster carers and external professionals described a collaborative approach to meeting the children's health needs and it was evident that appointments such as general practitioner appointments were facilitated by the foster carers. Children were offered choice in relation to their general practitioner and this was discussed and agreed upon before the placement commenced.

Inspectors found that medical consent was evident on children's files and information provided to inspectors outlined that this consent was signed once a child was placed with the foster care service. The service did not request sufficient information in relation to children's health needs at the point of referral. This included the requirement of an up to date care plan for each child which contains details of their health and medical needs. This meant that foster carers were not fully informed about the needs of children from the outset of the placement. Foster carers told inspectors that they built their knowledge of children's health needs over the course of the placement. Link worker case notes showed monitoring by the service of the level of health care provided to children.

Records showed that the majority of children had a medical assessment prior to their reception into care. However, it was not always clear if medical assessments were carried out prior to their placement within the service. Medical card details were on file for some children but not all. These gaps were identified as part of a service audit but had not resulted in any improvements.

There were a number of children who had a disability and their diagnosis was recorded on file. In some cases, there were up to date medical reports. Foster carers who met with inspectors said they were clear in relation to their responsibilities to meet children's health and medical needs. There was evidence of children attending various medical appointments.

Basic first aid training was provided by the service but this had not been completed by all foster carers as the service was in the process of scheduling this training. There was no guidance for foster carers in relation to the safe administration and management of medication

Education Needs

Children received appropriate education and support to maximise their potential. Education was valued by the service, the foster carers and external professionals involved with the children.

There was a very good level of school attendance for all children placed within the service. All children were in full time education. Inspectors visited some children in their placements and observed foster carers providing a suitable environment and encouragement to children to do their homework. Foster carers told inspectors that they support the children in relation to their attendance and assisted with homework. Some children told inspectors that they liked school and were involved with various school projects. Questionnaires returned by external professionals outlined that the service, foster carers and key professionals worked collaboratively to meet children's educational needs and foster carers maintained good contact with the schools and attended parent/teacher meetings, when appropriate.

The service maintained basic records in relation to children's educational needs. These records were found to be limited to what class the children were in, what school they attended and if additional supports were required. These records did not fully reflect how foster carers engaged with children's school and for example, if they attended meetings regarding the child's education. Inspectors found from a review of records that where children had additional educational needs, supports were put in place for them. When required, children were facilitated to attend a school specific to their educational needs and inspectors found that transport was provided by Tusla to help them maintain these placements. Efforts were made by the service to keep children in the school they attended prior to their placement. Some foster carers reported delays in accessing educational supports but this was resolved that the time of the inspection.

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 agency levels and all staff working in the agency are aware of their responsibilities. Risks to the service as well as to individual systems are well managed and the system is subject to a rigorous quality assurance system. Services are robustly monitored.

Inspection findings

Governance structures for the service were in the early stages of development and although there was a committed management team in place, management systems required improvement. A number of quality improvement initiatives were in the early stages of development to ensure the service was safe and effective but inspectors found that monitoring systems were not adequate. Risk management systems had not been fully developed and processes to ensure the service was safe and effective were not always effective. The management of risk was not sufficient and deficits were identified in a range of areas, particularly in relation to the management of child protection and welfare concerns. The service was not resourced to deliver the service effectively and some improvements were required in the supervision and training of staff. The service did not have a statement of purpose and function.

Management Structures and Systems

Governance structures were in place which provided lines of authority and accountability but they were in the early stages of development. Significant changes had been made to the governance arrangements for the service in 2016 which included a two tiered governance system. One was related to care practice and the other was in relation to the day to day business of the service. The service was governed by a board of management which had overall responsibility for the service. There was a sub group of the Board called the professional standards committee which had oversight of quality and practice development. The managing director explained that the new structure was developed to ensure there was sufficient oversight and leadership in relation to both business and practice development.

The managing director was appointed in a full-time capacity to the service in 2016 and prior to this she was also managing another branch of the company in another

jurisdiction. The managing director had a business background and had overall responsibility for managing the service. The managing director reported to the chief executive officer and the board of management. The newly established board of management had met on one occasion in September 2016 and the professional standards committee had met on three occasions. Minutes of these meetings showed that progress was being made in relation to oversight and leadership within the service.

The managing director told inspectors that deficits had been identified at a service level in relation to a number of aspects of service provision. A professionally qualified principal social worker was appointed in August 2016 to address these. The principal social worker had responsibility to oversee the provision of care and social work practice aspects of the service. The principal social worker was found to be competent and experienced and had identified key deficits in the service. She had engaged in key activities of service provision to gain operational knowledge of the service within a short period of time. This inspection found that the principal social worker showed leadership in terms of driving improvement and guiding staff in relation to their practice. However, due to the level of change and improvement required, and under resourcing of the service, the principal social worker was heavily involved in tasks which are usually assigned to staff such as link workers. This meant that the principal social worker could not dedicate the required amount of time to establishing effective systems of oversight, quality assurance and monitoring. The principal social worker identified the need for additional staff both at a link worker and team leader level to deliver the service effectively.

Staff members interviewed were satisfied with the management and governance of the service and they were clear about their roles and responsibilities. They said that managers demonstrated leadership through the provision of guidance and policy and they said that they were held to account for their practice. They told inspectors that managers were accessible and provided support to them on a daily basis. A number of external professionals said that there were improvements to communication and the delivery of the service since the appointment of the principal social worker.

The service had a suite of policies and procedures which were recently reviewed. There was a good system in place to develop and approve policies and procedures. Inspectors reviewed policies and procedures for the service and found that they provided adequate information and guidance to the staff team. However, the service had not developed some key policies such as an induction or a risk management policy. Some policies needed updating to include the establishment of Tusla. Foster carers were provided with a number of documents following their approval as foster carers. This included, for example, information about fostering, child protection and

safeguarding, as well as information about how to make a complaint. Foster carers who met with inspectors were aware of the service policies.

A register of children and a list of foster carers as required by the Regulations were not maintained by the service. Managers told inspectors that the service held relevant details related to children and foster carers but on review, inspectors found that this was not sufficient. The service provided 10 days respite care over a 12 month period for each child. There were electronic records maintained in relation to how many respite days were provided for each child but details of these placements were not retained. For example, the service recorded the number of respite days provided to children but it did not record which children were placed with which foster carers during these respite breaks. This meant that the service could not readily account for where children were placed at all times and did not maintain a fluid register of children which reflected their admission to and discharge from each placement.

The service had a system in place to record and report incidents and significant events. Inspectors examined these records and found that all significant events were notified to relevant parties such as the Tusla Monitoring Officer and social workers. Records showed that foster carers routinely reported all incidents and events, but there were delays from time to time.

There was a mix of formal and informal communication systems in the service. The service had an electronic information system which allowed relevant personnel to access information they required. The effectiveness of this system was dependent on in-putting of correct and up to date information by staff and managers. Inspectors reviewed various electronic records held by the service and found that link worker case notes were not always updated. Furthermore, there was no systematic way to label documents to ensure consistency and ease of access. Staff were satisfied with the level of communication across the service and said that they were kept well informed by managers. Inspectors found ample evidence of ongoing communication between the service and Tusla staff by way of phone calls, emails and meetings. External professionals said that levels of communication with the service had improved significantly in recent times and that Care Visions staff were available to them when required.

Planning the Service

The service had a business plan in place which was detailed and set out annual targets, priorities and service expectations. The business plan reflected key areas for improvement and ways to develop the service. The service was finalising the business plan for 2017. This was examined by inspectors and found to be comprehensive, with clear service objectives and how they were to be achieved. Service objectives were categorised under four key areas including outcomes for children, expanding the business, customer relations and staff and performance management. The business plan incorporated key performance indicators to support managers to map and assess progress. The managing director told inspectors that progress against the business plan was monitored through an action plan which was discussed at management meetings and then reported to the board of management. However, not all members of the management team were aware of key performance indicators for the service or the action plan. Inspectors found from a review of minutes of various meetings that the business plan was discussed but it was not an item on the agenda for board or professional standards meetings. Inspectors found that that some of the key performance indicators for 2015/16 had not been met but there was no analysis as to why this was the case. Furthermore, the service had focussed on the recruitment of foster carers without the required infrastructures being in place, such as sufficient link workers and support services.

Inspectors observed a senior management meeting where staff had the opportunity to consider the achievements from the previous year and identify priorities for the coming year. These included the development of a quality assurance framework and the implementation of an outcome monitoring framework. Inspectors observed staff being consulted in relation to service development and they identified the need to improve levels of participation and feedback from children and foster carers and children in the coming year.

The service did not have a statement of purpose and function which outlined what the service provided and to whom, and which supported service planning. This meant that the service had not identified the children whose needs it could meet within current resources. The managing director told inspectors that the service assesses every referral on a case by case basis and endeavours to meet the needs of any child referred. She explained that the service planned to expand and to increase its range and number of foster carers. However, this was not supported by a statement of purpose and function which set out the level of need the service could cater for, the resources it has to ensure these needs are met and a clearly identified set of admission criteria.

Risk Management

Risk management in the service required improvement. There were systems in place to identify and assess risk but these were in the early stages of development. The service had individualised policies and procedures to inform the management of risk in relation to child protection, safe care and health and safety but there was no overarching risk management policy to guide practice.

The service had recently developed a risk register which identified key risks for the service. The register categorised each risk, outlined the potential impact and identified actions required to mitigate against these risks. However, inspectors found that risks were not dated and control measures were not included. Although risks were rated according to potential impact, not all risks had been assessed. Examples of unassessed risks included the integrity of the service in relation to the quality of assessments. The risk register was discussed at the most recent professional standards committee meeting where gaps were identified and actions were put in place to address these. The managing director told inspectors that board members required improvements to the risk register and that this was an ongoing piece of work.

The service used a risk rating system as part of its electronic information system. This graded each child's placement as red, orange or green according to the risk associated with the placement. Inspectors examined the use of this system and found that not all placements were risk rated. Where they were, risk rationales were not routinely recorded. This undermined the effectiveness of the system. Inspectors found that there was no guidance for staff in relation to rating difficult placements. Link workers told inspectors that this process was not consistently implemented and therefore not a reliable source of information. There were no completed assessments of service risks and although some of the children's placements had a risk management plan, these were not always comprehensive or completed in a timely manner.

Serious and adverse incidents were not appropriately managed. Information returned to HIQA reported that in the 24 months prior to the inspection there had been 58 incidents. From review of these incidents, there were significant issues identified in the recording and reporting of such incidents. Inspectors found that some incidents were not serious enough to constitute a significant event and others, as mentioned elsewhere in this report, were of a child protection nature but were not categorised as such. Records of a large sample of events were reviewed by inspectors and although many were well recorded, others were not. Some were found to contain incorrect information, lacked detail and did not show what follow-up action was taken. Inspectors also found that records did not clearly categorise

the type of event or incident such as property damage, self-injurious behaviour, aggressive behaviour and so on. This did not support managers and recipients of these reports to trend events for individual children and did not indicate the seriousness of each event from the outset. The principal social worker acknowledged these issues and said that new report templates were being developed to improve the quality and structure of reports. The principal social worker told inspectors that she was working with staff and carers in relation to the correct categorisation of events. Records reviewed by inspectors, including emails to social workers, showed that the principal social worker had reviewed and re-categorised some notifications to reflect their level of seriousness.

Quality Assurance

There were some monitoring systems in place to assess and improve the quality and effectiveness of the service and to ensure compliance with national standards, but improvements were required. The service was in the early stages of developing a quality improvement framework. Current quality improvement initiatives had commenced including the professional standards committee which focused on quality of practice. In addition, the principal social worker had set up practice development meetings for link workers and the support worker to address any practice issues. Inspectors observed this meeting during the inspection, which was the first to take place. This was identified as a space to discuss and improve practice.

The service had commissioned an external professional to review the service against some of the national standards and this was carried out in February 2016. Inspectors were provided with a copy of this review and found that it provided an opportunity for the service to improve in various areas. An action plan was developed to meet the recommendations of this review and inspectors found that many of the actions had been implemented, which had resulted in improvements. However, the review did not cover all of the standards and there was a gap in relation to the assessment of how the service was performing in relation to areas such as governance and the promotion of children's rights. The managing director told inspectors that a further review of the service was planned for 2017.

Systems for routine auditing and monitoring of day-to-day practices were not sufficient. The principal social worker had a key role in monitoring the quality of the service provided to children and carers. Since her recent appointment, she had identified a number of deficits in relation to the quality of assessments and foster carer reviews. Inspectors viewed documentation to outline how she had escalated concerns in relation to this and a plan was in place to address the gaps. However, there was no routine auditing of other aspects of the service. Inspectors found

significant gaps in record keeping and follow up in relation to significant events, child protection and welfare issues, foster care agreements and vetting. File audits were completed but there was no evidence that gaps highlighted had been addressed or resolved. In addition, these audits were completed by members of the administration team with no input from the principal social worker from a qualitative perspective. There had been no overview of signification events, incidents, allegations or child protection notifications. Inspectors noted a number of concerns in relation to the recording, reporting and management of some incidents which had not been adequately addressed by the management team. Although these occurred before the principal social worker commenced in her role, systems were not robust to ensure all issues were identified and addressed, and children were appropriately safeguarded. The managing director and the principal social worker confirmed that there was no written handover of cases provided to the principal social worker by her predecessor, and given the level of complexities in comes cases identified by inspectors, this lack of due diligence was not sufficient.

There was a system in place to routinely monitor social work practice and the service provided to foster carers. Records showed that individual cases were reviewed during supervision of the link workers by the principal social worker.

The service was visited by a Tusla monitoring officer on one occasion in 2016. The managing director said the monitoring officer provided some verbal guidance in relation to service policies and procedures but there was no written report provided.

The service did not have a service level agreement with Tusla. Each placement had an individual agreement between the placing Tusla service area and Care Visions but this was not sufficient to ensure robust monitoring of the overall quality, safety and effectiveness of the service. The managing director said that although meetings had taken place with Tusla regarding a service level agreement, there was no progress to date.

There were some systems in place to collect and analyse data but they could be improved. The service had a computerised system to collect information about referrals, applicants, assessments and incidents within the service. In addition, the service maintained a number of logs to maintain information in relation to complaints and concerns. However, inspectors found that although significant events and concerns were reported to the professionals' standards committee, there was no overview or analysis of these. Reports were generated in relation to recruitment of foster carers and key information about the service but this was budget lead and not used to identify the needs of the service. There was no evidence of analysis of unplanned endings and opportunities for learning from such events were missed. There was no system in place to carry out a full evaluation of the service.

The service had developed systems to ensure participation of foster carers but seeking the views of children had not been facilitated at the time of the inspection. A foster care forum had taken place on four occasions and this facilitated good communication with foster carers about the service. This lead to the new initiatives within the service including the development of foster care support groups and participation days for children.

Theme 5: Use of Resources

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

Inspection findings

The service had a strategy in place for the recruitment of foster carers and there was a dedicated team in place to manage and expand the service. Although best use was made of current available resources, further resources were required. Retention strategies and supports for foster carers were in place but they were in the early stages of implementation.

Recruitment and Retention of foster carers

The service had a dedicated team to manage the recruitment of foster carers and they maintained a consistent approach to source an appropriate range of foster carers to meet the needs of the children referred to the service. Two recruitment campaigns were held in the last 12 months and the majority of recruitment drives took place through social media. The managing director said that this approach had proved successful to date. Information provided to HIQA prior to the inspection outlined that there were 1455 new enquiries about becoming a foster carer in the last 12 months. The average response time to these enquires was three days. The service had received 50 applications from prospective foster carers of which 44 were assessed.

Inspectors met with the recruitment and placement manager who had overall responsibility for the recruitment of foster carers. She explained that recruitment happened predominately through social media and the company's website. In addition, some enquires were received by phone. An initial telephone enquiry

screened applications and a follow up screening visit took place with potential applicants to gain more information prior to providing the interested parties with an application form. The recruitment and placement manager was from a business background but liaised with the principal social worker at all times throughout the screening process. This was to ensure that potential foster carers met the service criteria and had the skills to potentially become foster carers.

There was a policy and procedure in place for the recruitment and retention of foster carers. This was reviewed by inspectors and found to provide clear guidance in relation to the process. The service had a system in place to track progress in relation to meeting timelines for recruiting foster carers.

The managing director said that business targets were established to ensure the ongoing recruitment of foster carers. Figures provide to HIQA found that of the 44 carers assessed in the past 12 months, 10 were approved as foster carers. These figures showed that the service took a rigorous approach towards screening and assessment of foster carers. However, inspectors found that service needed to take a more proactive approach to providing information sessions to prospective foster carers. Inspectors found that once individual queries were made, further information sessions did not take place and there was a backlog of three applicants awaiting assessment. Inspectors observed an assessment meeting attended by the principal social worker and relevant personnel from the administration team. It was confirmed at this meeting that additional assessors were being recruited to meet current assessment demands, but there was no identified role for link workers in this process.

The service did not have a sufficient range of carers to cater for the needs of all children referred to the service, in particular in relation to carers from diverse backgrounds. In addition, there were insufficient carers to provide respite care and the managing director confirmed that they did not have any specialist foster care placements. This was confirmed by external professionals who spoke with inspectors and returned questionnaires. Over the course of the inspection, inspectors found that there were several children whose needs could not be met within the current foster care service. This was mainly due to the management of high levels of behaviours and as a result, alternative placements were or had been sourced for the children involved. Considering the fact that there was no statement of purpose for the service, it was not possible for Care Visions to identify the full range of foster carer resources required in order to meet the needs of the children admitted to the service. The business plan showed that Care Visions intended to increase the number and range of foster carers in the coming year.

There were some systems in place to retain foster carers and these were outlined in their policy related to the retention of foster carers. Inspectors found that each foster had an allocated link worker who provided regular support and supervision. Foster carers said they were happy with the support provided by their link workers but said they would like additional information about other supports available for them in their role such as family therapy and access to a range of professionals. There was a 24 hour on-call service available to foster carers who required support and advice outside of normal working hours and records showed that foster carers did access this support when required. In addition, foster carers could avail of 10 days respite breaks in any given year. Foster carer support groups had recently been set up and inspectors observed a discussion at a team meeting where the need to increase attendance at such events was discussed. From a review of files, it was found that sufficient efforts had been made by the service to encourage attendance at these groups. Foster carers told inspectors about an online facility where foster carers can support each other. There was an adequate system of oversight of this system by the support worker.

Other initiatives had recently taken place including a fun day at Dublin zoo and further events planned for later in the year. Feedback from foster carers was that these events were worthwhile.

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 agency recruit and manage their workforce to ensure that staff has the required skills, experience and competencies to respond to the needs of children.

Inspection findings

The foster care service was provided by a team who demonstrated commitment to their responsibilities. However, there was an insufficient number of qualified social workers to provide the services required and improvements were required in the training and supervision of staff. Recruitment practices were not as safe as they could be and significant improvements were required in relation to records.

Recruitment

Recruitment processes were not safe and not in accordance with legislation, standards and policies. Staff member's professional registration and qualification details were on file. Garda vetting checks were also in place for all staff. However, two staff members and been recruited and commenced in their role before Garda Vetting was completed. Inspectors found that not all staff had two references and job descriptions were not developed for all staff. This meant that roles and responsibilities and levels of accountability was not always clear.

The service recruited independent assessors to carry out assessments of prospective foster carers. There were eight active assessors and more were being recruited. This inspection found significant deficiencies in relation to vetting of some independent assessors. For example, Garda vetting was not in place for two assessors. International police checks were not carried out, where required. There was no evidence of qualifications for two assessors and two references were not obtained for all. Inspectors sought assurances from the service in relation to the safe recruitment of independent assessors and how it was going to manage current deficiencies. HIQA received a satisfactory response.

There was no policy to guide the induction programme for new staff. All staff interviewed said they were inducted in to the service but this was not evident in service records for all staff. A manager who was recently recruited described their induction to the service and said it included attendance at case meetings, training on use of the electronic system and a briefing from link workers on their cases. There was a checklist completed for this staff member which showed that all aspects of the service were not considered for induction purposes. This was confirmed by the staff member.

Sufficient staff and skill mix

Care Visions service was not sufficiently staffed in terms of numbers to meet service demands. The service comprised a managing director, principal social worker, two fostering link workers, one support worker and four administrative staff, which included an office manager and a recruitment and placement manager. It was acknowledged by the managing director and the principal social worker that there was a need for a team leader and additional link workers who were being recruited at the time of the inspection. Once these link workers were recruited, the managing director said that manageable caseloads would be allocated to ensure improved quality supports to foster carers.

The service had identified a need to ensure managers were experienced and

proficient in both business and practice matters. As such, the service manager attended to the day to day business of Care Visions and the principal social worker attended to practice issues. Both were skilled and experienced in these areas.

All social workers working within the service were professionally qualified and registered. Link workers were found by inspectors to be motivated and competent. However, they acknowledged their limited experience of working in foster care services. The principal social worker explained to inspectors that the service was committed to developing competence and up skilling the team. In order to do this, a practice development group was established.

This inspection found that some members of Care Visions foster care team carried out tasks and duties that were not commensurate with their qualifications. For example, there were members of staff with a business background screening prospective foster carers without any experience of working directly with children and families. In addition, the service was planning to enhance direct work with foster carers in managing behaviour that challenged which would be provided by a member of staff who was trained in this particular model but had no related formal qualification.

Supervision and support

Arrangements in place for the provision of supervision and the quality of supervision records required improvement. The managing director supervised the principal social work and managers on the administration team. The managing director told inspectors that to ensure good quality supervision in day to day care practice, additional supports were provided to the principal social worker by an external clinician.

The principal social worker supervised link workers, the support worker and independent assessors. Administrative staff that screened potential foster carers were not supervised by the principal social worker. Considering the tasks and level of contact with foster carers involved, this was not an adequate arrangement. Inspectors reviewed supervision records and found that frequency of supervision was not consistent and records lacked detail. Case management was an element of supervision and records in relation to cases were maintained separately. Inspectors examined a sample of case management records and found that decision making was transparent and staff were held to account for practice. Staff interviewed by inspectors valued supervision and were satisfied with the support and supervision provided by their line manager.

Care Visions acknowledged the need to introduce professional development plans for

the team. The service business plan reviewed by inspectors showed that this was a priority for 2017. Link workers told inspectors that they discussed their professional development in supervision but inspectors found that this was not well recorded.

There were other supports for staff by way of team meetings. Inspectors observed a team meeting and found that there was good discussion and decision making in relation to day to day issues.

Training

The service provided training to staff including training in the service model and information technology systems in use. Records showed that Care Visions supported staff to attend externally provided training so as to up skill and meet their registration requirements. However, there were significant gaps in relation to staff training. It was confirmed by service managers and staff that no staff had been trained in Children First (2011), since the service was established in 2013 but this had been scheduled to take place shortly after the inspection. Core training in relation to risk, rights and cultural diversity was not in place. In addition, the principal social worker told inspectors that there was no training needs analysis or training programme developed at the time of the inspection.

Appendix 1

National Standards for Foster Care (April 2003)
Theme 1: Child Centred Services
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.
Standard 2: Family and friends Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.
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.
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. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III Article 8 Religion*
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.

Theme 2: Safe and Effective Services
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*
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 board 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*
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

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.