

**NATIONAL STANDARDS**  
**FOR**  
**FOSTER CARE**



**DEPARTMENT  
OF HEALTH & CHILDREN**  
AN ROINN SLÁINTE  
AGUS LEANAÍ

**NATIONAL STANDARDS**  
**FOR**  
**FOSTER CARE**

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## FOREWORD

The vast majority of children in the care of the state now live with foster carers. A substantial number of these children are cared for by their extended family in relative foster care. Fostering services depend on families and individuals in the community who are willing to share their homes and lives with children and young people whose parents are unable to care for them. Foster carers also share their lives with a range of professionals with whom they work in partnership.

The Report of the Working Group on Foster Care, 'Foster Care: A Child-Centred Partnership', 2001 highlighted concerns about the quality of foster care services provided in Ireland. Following its publication, a committee was established to develop National Standards on Practices and Procedures on Foster Care. The group comprised representatives from the Department of Health and Children, the Social Services Inspectorate, the Irish Foster Care Association and professionals involved in the provision of foster care. A crucial task of the committee was to consult with persons and organisations with responsibility and an interest in the area of foster care, including a representative group of young people currently in foster care.

These Standards are based on the relevant legislation, regulation and guidance and best practice derived from evidence based research and professional experience from home and abroad. Additionally, the development of this document was influenced by the inspection experience of residential child care, feedback from foster carers and young people in care, the National Standards for Children's Residential Centres, and the outcome of the consultation process undertaken for the Foster Care Standards. The Social Services Inspectorate is responsible for inspecting foster care services managed by Health Boards.

It is the intention of the Department of Health and Children that these National Standards will serve as a basis for consistently promoting quality of care in the Foster Care services. These Standards apply only to those services provided under the Child Care (Placement of Children in Foster Care) Regulations, 1995 and the Child Care (Placement of Children with Relatives) Regulations, 1995. It is against these Standards that Inspectors will form judgements about the quality of Foster Care services. The Standards should provide useful and constructive guidelines for Health Boards and Foster Carers alike, as well as a basis for those in foster care and their families to judge the quality of the services they are receiving.

This document should be distributed to Health Board personnel involved in the Foster Care services, including referring or supervising social workers and their managers, foster carers and other professionals in statutory or non-statutory agencies. It should be available, along with the Children's Book of Foster Care, to children and young people in foster care, their families and any other persons who request it.

Finally, this document should be read in conjunction with the Child Care Act, 1991, the Child Care (Placement of Children in Foster Care) Regulations, 1995, the Child Care (Placement of Children with Relatives) Regulations, 1995, the Children Act, 2001, and the Report of the Working Group on Foster Care: 'Foster Care: A Child-Centred Partnership' (published May 2001).

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## SUMMARY OF STANDARDS

### SECTION ONE

#### THE CHILDREN AND YOUNG PEOPLE

- 1. Positive sense of identity**  
Children and young people are provided with foster care services that promote a positive sense of identity for them.
- 2. Family and friends**  
Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.
- 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.
- 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.
- 5. The child and family social worker**  
There is a designated social worker for each child and young person in foster care.
- 6. Assessment of children and young people**  
An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.
- 7. Care planning and review**  
Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.



- 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.
- 9. A safe and positive environment**  
Foster carers' homes provide a safe, healthy and nurturing environment for the children or young people.
- 10. Safeguarding and child protection**  
Children and young people in foster care are protected from abuse and neglect.
- 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.
- 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.
- 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.

## SECTION TWO

### THE FOSTER CARERS

#### 14. Assessment and approval of foster carers

##### 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.

##### 14b. Assessment and approval of relative foster carers

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

#### 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.

#### 16. Training

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

#### 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.

## SECTION THREE

### THE HEALTH BOARDS

- 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.
- 19. Management and monitoring of foster care services**  
Health boards have effective structures in place for the management and monitoring of foster care services.
- 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.
- 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.
- 22. Special foster care**  
Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.
- 23. The foster care committee**  
Health boards have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice.
- 24. Placement of children through non-statutory agencies**  
Health boards placing children or young people with a foster carer through a non-statutory agency are responsible for satisfying themselves that the statutory requirements are met and that the children or young people receive a high quality service.
- 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.

# SECTION ONE

## THE CHILDREN AND YOUNG PEOPLE

### 1

#### Positive sense of identity

*Children and young people are provided with foster care services that promote a positive sense of identity for them.*

#### CRITERIA

- 1.1 Foster carers and social workers promote the self-confidence and self-esteem of children in foster care by:
  - listening to them;
  - involving them when decisions about their care are being made;
  - showing respect for them, their families, their culture and ethnicity (including membership of the Traveller community), religion, sexual identity, illness, disability and stage of development;
  - working in partnership with their families.
- 1.2 Health boards, in the first instance, seek to identify and support any relative or friend of the child who can provide an appropriate placement which meets the child's assessed need. These efforts are recorded on the case file.
- 1.3 Priority is given to the placement of siblings together, unless this is inappropriate given the assessed needs of the children.
- 1.4 Priority is given to the placement of children in their local community, unless this is inappropriate.
- 1.5 Care arrangements facilitate contact between children and their families, friends, significant others and communities. Foster carers and professionals who have been involved in the care of children are encouraged to maintain links and mark special events.
- 1.6 Where possible and in their best interests, children are facilitated to remain at the school attended prior to placement.
- 1.7 Social workers, foster carers and other professionals are non-judgemental about children's families.

- 1.8 Children's access to accurate, relevant and comprehensive information about their background and history, both in their family and in care, is encouraged and facilitated.
- 1.9 Child and family social workers compile and maintain comprehensive records that can be reproduced in legible form. Decisions made to withhold information, or to delay provision of it on account of age or other factors, are recorded on the case file.
- 1.10 Parents, extended families and other significant others are consulted in the information gathering process.
- 1.11 Foster carers recognise the importance of personal items from the children's past for their sense of self and assist the children to retain letters, cards, photographs and other precious keepsakes.
- 1.12 Children are assisted by foster carers, social workers and other professionals to understand events in their lives.
- 1.13 Where possible, the same placement is used each time respite care is provided to ensure continuity of care for children in foster care.
- 1.14 In the first instance, when children are re-entering care, previous foster carers are approached to care for them, unless this is inappropriate.
- 1.15 The particular needs of children with disabilities are recognised and these are met in a manner that promotes a positive sense of identity for them.

## FAMILY AND FRIENDS

# 2

*Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.*

### CRITERIA

- 2.1 Children's need for contact with family and friends is considered when making a foster placement, especially where they are placed outside of their local community.
- 2.2 Siblings are placed together where possible, taking account of their wishes. If they are not accommodated together, arrangements are made for them to have high levels of contact, including holidays together, provided this in their best interests.
- 2.3 The child and family social worker ensures that contact is maintained with family members and friends as set out in the care plan.
- 2.4 The families of children in foster care are involved in their care, in partnership with social workers and foster carers, unless this is detrimental to the well being of the children, in which case the reasons for excluding them are recorded on the case files and the parents are advised in writing of their right to appeal.
- 2.5 Children, in partnership with their families, are facilitated in identifying people they regard as significant in their lives, including family members, neighbours and friends. Their wishes in relation to contact are ascertained and, where possible, facilitated.
- 2.6 Health boards have procedures setting out how arrangements for contact between children in foster care and their family and friends are established, maintained, monitored and reviewed.
- 2.7 Children are encouraged and facilitated to use a variety of media to maintain contact with family and friends such as post, phone, text and email.
- 2.8 Health boards provide practical support to family members and friends to facilitate contact, such as adequate assistance with transport arrangements or costs.

- 2.9 Where possible, access takes place in the foster home. Health boards provide suitable and appropriate access facilities for those visits that take place outside of the foster or family home.
- 2.10 Where access is supervised, the reasons for this are explained carefully to the children, their families and foster carers and recorded on the case file. The child and family social worker consults with them about how the supervision can be managed in the least intrusive manner consistent with the need to safeguard the children. The decision to supervise access is subject to regular review.
- 2.11 Parents and/or significant family members are kept informed of events in their children's lives and this is recorded on the case file.
- 2.12 Parents and/or other family members are encouraged to contribute to their children's lives and to participate in key events, unless this is deemed inappropriate.
- 2.13 Where children do not have contact with their families, the child and family social worker and foster carer discuss the reasons for this with the children from time to time and the case file records that these discussions took place.
- 2.14 The children's need for peer relationships is recognised. Consistent with safeguarding and promoting the children's wellbeing, checks on friends and their families are carried out in the least intrusive manner.

## CHILDREN'S RIGHTS

# 3

*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.*

### CRITERIA

#### Dignity

- 3.1 Children are provided with personal care appropriate to their age, stage of development, gender, culture, ethnicity, religion, and individual needs.
- 3.2 Children are enabled to be independent, consistent with their age, stage of development and individual needs.

#### Privacy

- 3.3 Children are facilitated to have undisturbed contact with family and friends, unless there are clear reasons not to do so.
- 3.4 Children's correspondence and personal effects are respected.
- 3.5 Children have age-appropriate opportunities to be alone.

#### Choice

- 3.6 Children are encouraged and enabled to develop their abilities, aptitudes, skills and interests.
- 3.7 Children are consulted and heard in all decisions about their care and their views are given due weight in accordance with their age, stage of development and individual needs.
- 3.8 Consistent with their age, stage of development and individual needs, children have access to information about services available to them and information held on their case files in order to form opinions and exercise choice. They are facilitated to correct any inaccuracies in the information held on their files and given appropriate support when accessing sensitive information.
- 3.9 Children are encouraged to exercise choice across a range of daily activities such as buying clothes, saving and spending money, and hobbies.



- 3.10 Children are told about the complaints procedure, given a written copy of it in an age-appropriate format and assisted, where necessary, to make a complaint about their care. Their complaints are taken seriously and, in the first instance, dealt with locally and promptly.

## VALUING DIVERSITY

# 4

*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.*

### CRITERIA

- 4.1 Children are encouraged to understand and appreciate their cultural, ethnic and religious heritage.
- 4.2 Children and young people are encouraged and facilitated to observe the religious practices of their families (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 8 and Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 8*) and to give appropriate expression to their cultural, ethnic and sexual identity.
- 4.3 Wherever possible, children are placed with carers from their own cultural, ethnic and religious group.
- 4.4 Where children are placed outside their cultural, ethnic or religious group, foster carers are supported to enable the children to develop a positive understanding of their origins and background.
- 4.5 Children are encouraged and facilitated to understand and manage their disability and/or illness in accordance with their age, stage of development, individual needs and wishes.
- 4.6 Children are supported and encouraged to develop skills to deal with all forms of discrimination.
- 4.7 Children with disabilities receive appropriate services and support to help them to maximise their potential, including equipment and, where necessary, the adaptation of the carer's home and/ or vehicle.
- 4.8 The right of children to participate in all decisions in relation to their care is facilitated through access to advocacy and support services.

## THE CHILD AND FAMILY SOCIAL WORKER

# 5

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

### CRITERIA

- 5.1 Health boards allocate a social worker to children as soon as the need for an admission to care is identified and for as long as they remain in care.
- 5.2 Social workers co-ordinate the care of the children, and have responsibility for:
- ensuring compliance with statutory requirements and standards;
  - arranging assessments;
  - drawing up care plans and ensuring decisions are implemented;
  - placing children in foster care;
  - arranging care plan reviews and ensuring that decisions are implemented;
  - ensuring that the views of children and their families are taken into account and that they are enabled to participate in the care planning process;
  - visiting children in the foster home and meeting with them in private within the first month of placement, at least every three months during the first two years of placement and at intervals not exceeding six months thereafter (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part IV, Article 17 (1)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part IV, Article 17 (1)*);
  - working in partnership with families to maintain links and facilitate access where this is in the best interests of the children;
  - taking appropriate action in response to significant events and ensuring families are informed;
  - ensuring that the welfare of the children is promoted and that they are protected from abuse;
  - ensuring access to specialist services;
  - co-ordinating the input of other professionals and agencies;
  - keeping an up-to-date case file in respect of each child that includes a record of each visit to the child;
  - explaining the complaints procedure to the children, providing a written copy of that procedure and assisting the children, where necessary, to complain about any aspect of their care.

## ASSESSMENT OF CHILDREN AND YOUNG PEOPLE

# 6

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

### CRITERIA

- 6.1 The decision to use a foster care placement is based on an assessment which determines this to be in the best interests of the child.
- 6.2 Child and family social workers ensure that the assessments are carried out prior to placement. They are comprehensive and, where appropriate, multidisciplinary. They consider the emotional, psychological, medical, educational and other needs of children (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 6(1)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 7(1)*) and take account of any previous assessments of the children.
- 6.3 In the case of decisions to place children in foster care in an emergency, the health board ensures completion of an initial assessment of the children within one week of placement and the completion of the comprehensive assessment within six weeks. Unplanned admissions to foster care are made in exceptional circumstances only and the reasons for them are recorded on the case file.
- 6.4 Children, their families and others involved in their care are encouraged and facilitated to participate in the assessment process.
- 6.5 Assessment outcomes are shared with the children in an age-appropriate manner and copies of the assessment are given to the family and foster carer/s. Decisions are recorded and attached to the assessment report on the case file.

## CARE PLANNING AND REVIEW

# 7

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

### CRITERIA

- 7.1 Child and family social workers, in consultation with the children, their families, foster carers and significant others draw up comprehensive, written care plans that are kept on the case file (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 11* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 11*). The disability services are involved in drawing up care plans for children with disabilities.
- 7.2 Care plans are prepared before the child is placed (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 11* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 11*), or, in the case of an emergency placement, within 14 days.
- 7.3 Care plans are informed by the assessments of the child's needs.
- 7.4 Care plans set out:
- the immediate, medium and long term goals and arrangements for the care of the child;
  - the aims and objectives of the placement;
  - the arrangements for the implementation of the care plan including the allocation of tasks to named individuals and timescales for their completion or review as appropriate;
  - the supports to be provided to the child and the foster carers;
  - the supports to be provided by the health board to help the family to implement those parts of the care plan that apply to them;
  - the access arrangements;
  - the arrangements to review the care plan (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part IV, Article 18* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part IV, Article 18*);
  - the arrangements for the child's education;
  - the expected duration of the placement.

- 7.5 Separate placement plan agreements are completed, dated and signed by the child and family social worker and the link worker with the foster carer/s in respect of each placement of the child. The agreements are consistent with the care plan.
- 7.6 Particulars of the child's care plan and placement plan agreement are made known to the child, parents, where appropriate, foster carer/s and link worker (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 11(4)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 11(4)*). Reasons for not doing so are recorded on case files.
- 7.7 Reviews of the care plan take place within legally defined time limits. Additional reviews are convened as necessary (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part IV, Articles 18, 19 and 20* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part IV, Articles 18, 19 and 20*). The reviews consider whether:
- the circumstances of the parents of the child have changed;
  - the circumstances of the foster placement have changed;
  - it would be in the best interests of the child to return to the parents' care;
  - adoption is in the best interests of a child in long-term foster care;
  - the care plan and its overall goal requires to be amended.
- 7.8 Reviews are convened and conducted in a manner that facilitates children, their families and foster carers.
- 7.9 The child and family social worker and the link worker participate in care plan reviews. Other professionals involved with the care, protection, education, health and development of the child are invited to contribute to the review by attending and/ or by submitting a report.
- 7.10 The outcome of the meeting is discussed with the child, in accordance with his or her age, stage of development and individual needs, the parents, where appropriate, and the foster carers. A written account of the decisions of the review is given to the child, the parents, where appropriate and the foster carers and a copy is retained on the case file.
- 7.11 When a placement is at risk of ending in an unplanned way, a review is held to assess the situation.
- 7.12 When a placement ends in an unplanned way, a review is held to bring it to a formal conclusion and to amend the care plan to take account of the changed circumstances.

## MATCHING CARERS WITH CHILDREN AND YOUNG PEOPLE

# 8

*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.*

### CRITERIA

- 8.1 Health boards, in selecting carers to foster children in their care, ensure that the carers have the capacity to meet the needs of the children concerned (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 7*).
- 8.2 Children, where possible, spend some time with the proposed foster care families prior to placement, so that they can express an informed view about the planned move.
- 8.3 Matching carers with children is based on the written assessment of the children's needs and their care plans. The children's views are considered in accordance with their age, stage of development and individual needs.
- 8.4 Matches are achieved by means of information sharing and discussion involving all relevant professionals, the children and their families, where appropriate, and the proposed foster carers, their families and other children in the placements.
- 8.5 Child and family social workers seek to establish links between the children's family and the foster carers to enable the children to settle in their new placement.
- 8.6 The appropriateness of the match is reconsidered if the plan for the care of the child changes, or the circumstances of the foster carers change.

## A SAFE AND POSITIVE ENVIRONMENT

# 9

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

### CRITERIA

- 9.1 Children are cared for with affection. They are valued, accepted and supported. Their welfare is promoted, and their developmental needs are met.
- 9.2 Foster carers provide a stimulating environment and opportunities for play and learning.
- 9.3 Children are supported and encouraged to maintain family links, friendships and interests, unless this is not in their best interests, and are encouraged and supported in making new contacts.
- 9.4 Children have adequate, appropriate and well-maintained clothing.
- 9.5 Children are provided with an adequate, appropriate, nutritious and varied diet that takes account of personal preferences, cultural, ethnic and religious considerations, and any special dietary requirements.
- 9.6 Health boards ensure that the foster care accommodation, furnishings and facilities:
  - are safe;
  - are adequate and sufficient for the number of people living in the home;
  - are maintained to a good standard of cleanliness and hygiene;
  - reflect the children's need for privacy and space.
- 9.7 Foster carers' homes and their immediate environments are free of avoidable hazards that might expose children to risk of injury or harm.
- 9.8 Health boards ensure that, where foster carers provide transport, vehicles are safe and that legal requirements are met.



## SAFEGUARDING AND CHILD PROTECTION

# 10

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

**NOTE: This Standard is to be read in conjunction with attached Guidance Note on Safeguarding and Child Protection in Foster Care at Appendix 1.**

### CRITERIA

#### Safeguarding

- 10.1 Link workers ensure that the preparation of foster carers includes guidance and training in:
- caring for children who have been neglected or abused;
  - safe care practices;
  - recognising and reporting signs of abuse;
  - understanding and managing challenging behaviour;
  - maintaining a record of the foster placement.
- 10.2 Link workers advise foster carers on the appropriate use of sanctions and ensure that they understand that corporal punishment in any form, for example, slapping, smacking, shaking or any form of humiliating treatment is unacceptable and prohibited.
- 10.3 Foster carers and social workers are aware of the particular vulnerability of children in care to bullying and abuse; procedures are in place to identify, record and address any instance of bullying or victimisation.
- 10.4 Foster carers are given full information in writing about the children to enable them to protect the children, the foster carers themselves, their own children or other children who may have contact with children in their foster care. This information is treated in confidence and stored securely.
- 10.5 Link workers ensure that clear guidelines are given to foster carers on what they are required to do if children go missing from their care.
- 10.6 Generally, no more than two children are placed in the same foster home at any one time, except in the case of sibling groups and these are not placed with other fostered children. The foster care committee must approve any departure from this practice in advance of the placement.

- 10.7 Foster carers are informed of their right to refuse to accept a placement and understand that health boards respect their decisions.
- 10.8 Health boards ensure that foster carers have ready access to respite care, counselling and out-of-hours consultation and advice services as agreed in the care plan.
- 10.9 The child and family social worker ensures that the children are taught appropriate self-care and self-protection skills.

### **Child Protection**

- 10.10 An allegation of abuse or neglect or suspected abuse or neglect in relation to children in foster care regarding past or current incidents, involving persons known or unknown to the children, are dealt with under child protection procedures that comply with Children First, the National Guidelines for the Protection and Welfare of Children (1999).
- 10.11 Whenever an allegation of abuse or neglect or suspected abuse or neglect are raised the health board carries out an assessment of possible risk to all children in the foster placement. This assessment informs the decision whether to maintain the placement. The assessment team includes a qualified practitioner from outside the community care area.
- 10.12 Children in foster care are given an explanation of any allegation of abuse or neglect or suspected abuse or neglect where appropriate.
- 10.13 Children in foster care who disclose abuse or neglect are assured that their concerns are taken seriously and acted on. They are offered continuous support and are kept informed of developments throughout the process of assessment and, if applicable, Garda investigation. They are provided with counselling and/or therapy to help them to deal with what has occurred and with the consequences of disclosure.
- 10.14 The parents or guardians of the children are informed of any allegation within three working days of it being received, unless to do so would prejudice any Garda investigation or put the children at risk.
- 10.15 Foster carers against whom allegations of abuse have been made are informed in writing of:
- the allegation made against them, unless to do so would prejudice any Garda investigation or put the children at risk;
  - the assessment procedure and regular updates of its progress;
  - the outcome of the assessment and of any Garda investigation.

- 10.16 Foster carers against whom allegations have been made are treated with dignity and respect throughout the process of assessment and, if applicable, Garda investigation.
- 10.17 Health boards have appeals mechanisms in place, in accordance with Standard 25, for foster carers against whom allegations of abuse or neglect have been made and who are unhappy with the outcome of the assessment.
- 10.18 Where allegations of abuse or neglect or suspected abuse or neglect are being assessed and/or investigated health boards offer the foster carers and all children and young people in the home appropriate counselling and support.
- 10.19 The foster care committee reconsiders the foster carer's approval once the assessment and, if applicable, the Garda investigation is concluded.
- 10.20 Health boards maintain detailed records of assessments and Garda investigations of abuse involving foster carers and the outcome of these and, where appropriate, use these to inform its approach to training, support and supervision etc. of foster carers.

## HEALTH AND DEVELOPMENT

# 11

*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.*

**Note: This standard is to be read in conjunction with attached Guidance Note regarding Medical Consent issues at Appendix 2.**

### CRITERIA

- 11.1 The issue of consent to medical and dental treatment is discussed with the parents and foster carers of children at, or before, placement in foster care and they are given written information with regard to their rights and duties in this matter.
- 11.2 Health boards have procedures in place to ensure that appropriate consent can be given in a timely manner in respect of elective procedures.
- 11.3 Children undergo a medical and developmental examination on admission to care except where the health board is satisfied, having regard to available information and reports, that such an examination is unnecessary (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 6 (1)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 7 (1)*).
- 11.4 Children and their parents are consulted regarding their health care and treatment plans, including immunisations. Young people aged 16 and over consent to medical examinations or treatment, in accordance with the Non-Fatal Offences Against the Person Act, 1997, Section 23(1).
- 11.5 Children in foster care have their own medical cards.
- 11.6 Children have prioritised access to medical, psychiatric, psychological, dental, ophthalmic, therapeutic and other specialist services and treatment when required.
- 11.7 Where possible and appropriate, children continue to attend their family GP. Where a change is required the wishes of the children are ascertained and facilitated and their medical histories are transferred.
- 11.8 Child and family social workers and foster carers share information with GPs to enable appropriate care/ treatment to be provided.

- 11.9 Case records contain clear and complete records of all health and development information from birth. Efforts made to obtain any missing information are recorded on case files.
- 11.10 Foster carers take all reasonable measures to promote the health and development of children placed in their care.
- 11.11 Foster carers administer routine first aid to a child in their care who has received a minor injury.
- 11.12 Foster carers seek appropriate medical aid for a child in their care who suffers illness or injury (*Child Care (Placement of Children in Foster Care) Regulations 1995, Article 16(2)(d)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Article 16(2)(d)*).
- 11.13 Foster carers contact the health board when a child in their care needs elective medical or dental treatment and the health board notifies the parent/s, where appropriate.
- 11.14 Foster carers maintain a record of all prescribed medication administered.
- 11.15 Care plans designate the person responsible for giving age appropriate advice and guidance on issues of physical, emotional and sexual health and development.
- 11.16 Children are given accurate information about their health and developmental history and that of their families, in accordance with their age, stage of development and individual needs.
- 11.17 Foster carers receive basic training on first aid, health and hygiene issues, with particular emphasis on health promotion and communicable diseases.

## EDUCATION

# 12

*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.*

### CRITERIA

- 12.1 Health boards encourage and support schools in promoting both continuity and quality of education for children in foster care.
- 12.2 In liaison with school personnel, the children's educational needs and progress are considered and recorded in assessments, care plans and reviews. Appropriate educational attainment targets are agreed, and supports necessary for the achievement of the targets are put in place.
- 12.3 The roles of the parents, foster carers and social workers in promoting children's education are clearly defined in care plans. Responsibility for contact with the school is clearly assigned and accepted.
- 12.4 Child and family social workers and foster carers share such information with schools as to enable them to offer appropriate help and support to children in foster care. The child and family social worker ensures that the school understands that the information provided is confidential.
- 12.5 Education and learning are valued in foster homes. Foster carers expect children to attend and attain at school and support this through provision of books, equipment and uniform, assistance with homework and financial, practical and moral support for participation in extracurricular activities.
- 12.6 Foster carers provide opportunities for the children to develop social and life skills and encourage and facilitate their participation in hobbies and interests.
- 12.7 Health boards ensure that, where appropriate, the social and learning development of pre-school children is stimulated through provision of opportunities for attendance at playgroups or nursery schools.
- 12.8 Young people approaching school leaving age are actively encouraged to participate in third level education or vocational training programmes as appropriate to their abilities, interests and aspirations. This is specified in their care plans.

- 12.9 Child and family social workers, in consultation with foster carers, ensure that concerns regarding school are brought to the prompt attention of staff at the school, and that an effective plan of action is agreed with the school and recorded on the case file.
- 12.10 Child and family social workers are aware of the procedures for the exclusion of children from a school and know how to appeal against such decisions.

## PREPARATION FOR LEAVING CARE AND ADULT LIFE

# 13

*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.*

### CRITERIA

- 13.1 Health boards have a written policy on after care provision. This outlines all aspects of support and entitlement for children and young people leaving care.
- 13.2 At least two years prior to a young person reaching the legal age for leaving care, the care plan outlines the personal and financial supports that will be available to the young person, the living arrangements and the support available in times of crisis or seasonal celebration.
- 13.3 The after care planning for a young person with a disability involves consultation with the adult disability service in order to provide a seamless transition to that service for the young person on reaching adulthood.
- 13.4 Health boards provide an after care service as set out in the Child Care Act 1991, Part VI, Section 45. This service is available to all young people who have been in care, including early care leavers and those whose placements end in an unplanned way.
- 13.5 Young people, their families and foster carers are involved in developing their leaving care plans.
- 13.6 Children are encouraged by their foster carers to be actively involved in the daily routines of family life, such as purchasing and preparing food, choosing of décor and learning to budget their pocket money.
- 13.7 Acceptable levels of independence and risk taking by children is encouraged having due regard to their age, stage of development, understanding, competence and ability.
- 13.8 Children are prepared for leaving foster care in ways that are appropriate to their age, stage of development, understanding and maturity. The preparation reflects whether the future plan is for them to live with their families, with other families or in specified other arrangements.
- 13.9 Young people are made aware of the range of supports available to them from health boards and other relevant agencies and are encouraged to use these.



- 13.10 Young people are encouraged to maintain contacts with their local community and to make full use of available services.
- 13.11 Foster carers are facilitated and supported financially, where appropriate and as agreed by the health board, to provide ongoing support to young people, including those aged 18 and over, who continue to live with them.

## SECTION TWO

### THE FOSTER CARERS

#### ASSESSMENT AND APPROVAL OF FOSTER CARERS

# 14

#### 14(a) Non-relative foster carers

#### 14(b) Relative foster carers

#### 14(a) 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.*

- 14<sup>a</sup>.1 Health boards have clear, written policies on the assessment and approval of foster carers and clear assessment procedures to enable them to approve and match foster carers to the needs of children in their care.
- 14<sup>a</sup>.2 Persons who apply to become foster carers receive written information and a clear explanation of:
- the process of assessment;
  - the criteria against which they will be assessed;
  - the qualities they will be expected to demonstrate;
  - the professional supports available to foster carers;
  - the health board's commitment to equal opportunities;
  - the allowance payable;
  - the appeals procedure.
- 14<sup>a</sup>.3 Persons who apply to become foster carers undergo a formal assessment carried out by a suitably qualified and trained social worker. The assessment report concludes with a recommendation to the foster care committee as to whether the applicants should be approved and, if so, what services they could offer.
- 14<sup>a</sup>.4 The progress of the assessment is regularly discussed with the applicants. The assessment is completed within 16 weeks of their formal application, unless more time is required. They are informed of the reasons for any extension and given a new completion date.

- 14<sup>a</sup>.5 In order to ascertain the applicants' suitability, health boards carry out checks of their own relevant records and of those of other health boards or equivalent authorities in other countries where the applicants have previously lived.
- 14<sup>a</sup>.6 Foster care applicants participate in the assessment process and supply to the health board such information as is necessary for the completion of an assessment of their suitability including: medical information, authorisation to enable the health board to carry out Garda checks, and names and addresses of referees (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 5 (2) (a)*).
- 14<sup>a</sup>.7 Garda clearances are obtained on all adults living in, or with significant unsupervised access to foster homes, before the carers are approved or a first placement is made.
- 14<sup>a</sup>.8 The applicant's household is assessed and all family members including children, in accordance with their age, stage of development and individual needs, are involved in the assessment process.
- 14<sup>a</sup>.9 Foster care applicants have access to their assessment report before a recommendation is made and candidates have a right to add their own comments to the report for the consideration of the foster care committee.
- 14<sup>a</sup>.10 Foster care applicants are given an option to meet the foster care committee that considers their application.
- 14<sup>a</sup>.11 Assessment reports are considered by the foster care committee. It decides whether to recommend the applicants to the health board for inclusion on its foster care panel. Applicants are informed in writing of the health board's decision.
- 14<sup>a</sup>.12 Following approval, a formal written contract with foster carers in respect of each child placed with them is concluded by health boards, and the carers are given a copy of each contract (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 9 (1), (2)*).

#### **14<sup>b</sup> ASSESSMENT AND APPROVAL OF RELATIVE FOSTER CARERS**

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

- 14<sup>b</sup>.1 Health boards have clear, written policies on the assessment and approval of relative foster carers, and clear assessment procedures to enable them to approve and match relative foster carers to the needs of children in their care.

- 14<sup>b</sup>.2 Relatives who apply, or are requested to apply, to become foster carers receive written information and a clear explanation of:
- the process of assessment;
  - the criteria against which they will be assessed;
  - the qualities they will be expected to demonstrate;
  - the professional supports available;
  - the health board's commitment to equal opportunities;
  - the allowance payable;
  - the appeals procedure.
- 14<sup>b</sup>.3 Relatives who apply, or are requested to apply, to become foster carers undergo a formal assessment carried out by a suitably qualified and trained social worker. The assessment report concludes with a recommendation to the foster care committee as to whether the applicants should be approved.
- 14<sup>b</sup>.4 The process of assessment takes account of the context in which the application to care for a particular child or children arises.
- 14<sup>b</sup>.5 The progress of the assessment is regularly discussed with the applicants. The assessment is completed within 16 weeks of their formal application, unless more time is required. They are informed of the reasons for any extension and given a new completion date.
- 14<sup>b</sup>.6 In order to ascertain the applicants' suitability, health boards carry out checks of their own relevant records and of those of other health boards or equivalent authorities in other countries where the applicants have previously lived.
- 14<sup>b</sup>.7 Relative foster care applicants participate in the assessment process and supply to the health board such information as is necessary for the completion of an assessment of their suitability including: medical information, authorisation to enable the health board to carry out Garda checks, and names and addresses of referees (*Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 5(1)(a)*).
- 14<sup>b</sup>.8 Garda clearances are obtained on all adults living in, or with significant unsupervised access to the home, before the carers are approved or a first placement is made.
- 14<sup>b</sup>.9 The applicant's household is assessed and all family members including children, in accordance with their age, stage of development and individual needs, are involved in the assessment process.

- 14<sup>b</sup>.10 Relative foster care applicants have access to their assessment report before a recommendation is made, and have a right to add their own comments to the report for the consideration of the foster care committee.
- 14<sup>b</sup>.11 Relative foster care applicants are given an option to meet the foster care committee that considers their application.
- 14<sup>b</sup>.12 Assessment reports are considered by the foster care committee. It decides whether to recommend the applicants to the health board for approval as relative foster carers. Applicants are informed of the health board's decision in writing.
- 14<sup>b</sup>.13 Following approval, a formal written contract with relative foster carers in respect of each child placed with them is concluded by health boards and the carers are given a copy of each contract (*Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 9 (1), (2)*).

## SUPERVISION AND SUPPORT

# 15

***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.***

### CRITERIA

- 15.1 Once foster carers are approved, health boards assign a named social worker, known as the link worker, to provide information, advice and support to them.
- 15.2 Health boards have written protocols that:
- define the roles of the link worker, and the child and family social worker but allow for negotiation in relation to the carrying out of specific tasks, especially in relation to the assessment and support of relative foster carers;
  - ensure clear lines of communication between them;
  - facilitate the exchange of reports relevant to the placement within specified time limits.
- 15.3 Link workers responsibilities generally include:
- organising training;
  - providing regular supervision and support for foster carers and their children;
  - ensuring that foster carers understand, accept and operate within all relevant standards, policies and guidance of the health board;
  - ensuring that foster carers receive all relevant information and advice about the children including: background history, health, education, cultural, ethnic, religious, and sexual development issues, vulnerabilities and risks, and information regarding neglect or abuse the children may have suffered;
  - providing foster carers with specific written information on, and explanations of, health board procedures should a complaint or allegation be made against them and the supports available in such an event;
  - providing foster carers with specific written information on health board procedures to be followed should a child go missing from their care;

- ensuring that counselling is available to foster carers and their children where a placement breakdown has occurred, or after other critical events.
- 15.4 Link workers meet with foster carers on a regular basis and have separate meetings with the foster carers own children.
- 15.5 Child and family social workers and link workers visit the foster carer's home together to make arrangements for any new placement, and draw up an agreed placement plan.
- 15.6 Link social workers maintain a record of all contacts with foster carers, including the issues discussed, requests for additional support and the response to these requests.
- 15.7 Foster carers are informed of their right of access to records pertaining to them.
- 15.8 Health boards ensure that there are support groups for foster carers and their children in each local area.
- 15.9 Health boards have an out of hours service to help foster carers in emergency situations, foster carers are informed in writing how to access this service.

## TRAINING

# 16

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

### CRITERIA

- 16.1 Health boards have a strategy for the training of foster carers, the children of foster carers, where appropriate, and professionals involved in foster care, including opportunities for joint training. The strategy also addresses the specific training needs of relative foster carers.
- 16.2 Training programmes take account of assessed training needs, child care policy and practice, research, inspection findings and best practice.
- 16.3 Health boards periodically evaluate the training programmes for those involved in foster care.
- 16.4 Health boards ensure that training is organised in such a way as to encourage and facilitate attendance by foster carers.
- 16.5 Training is delivered within an equal opportunities framework.
- 16.6 Applicants and foster carers commit to participate in appropriate training programmes.
- 16.7 Where necessary, foster carers receive training on key areas relevant to the specific needs of an individual child before his/her placement.
- 16.8 Link workers maintain records of all training undertaken by each foster carer.
- 16.9 Foster carers' reviews include an appraisal of their training needs and this forms the basis of the training programme for the following year.



## REVIEWS OF FOSTER CARERS

# 17

*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.*

### CRITERIA

- 17.1 The first review is held one year after the first placement has been made. Subsequent reviews take place at three yearly intervals.
- 17.2 After the first review, each subsequent review includes updates of Garda checks.
- 17.3 Following an agreed format, reviews consider the performance of the foster carers, their training requirements, significant changes in their circumstances, their health, and the adequacy of the supports and training provided by the health board.
- 17.4 Link workers and foster carers prepare an agreed report for the review in consultation with all members of the household.
- 17.5 In preparing the report, link workers elicit and document the views of the child and family social workers, the children and, unless this is inappropriate, their parents.
- 17.6 Review reports record training undertaken and outline actions to be taken by the foster carers and the health boards, including training and support, in the period up to the next review.
- 17.7 Where their views are different from those of the parties contributing to the link worker's report, foster carers are encouraged and facilitated to prepare a separate report for reviews.
- 17.8 If there are separate reports these are exchanged at least one week before the review meeting.
- 17.9 Review meetings are attended by link workers, foster carers and other members of the household, as appropriate, and are chaired by a social worker at managerial level.
- 17.10 Where the parties to the review agree a recommendation is added to their report for the foster care committee regarding the ongoing status of the foster carer.

Where they do not agree, a written account of the issues is submitted to the committee for its consideration. Foster carers may, if they so wish, meet with the committee to discuss the matter, or the committee may request to meet with them. Foster carers are notified in writing of the outcome of any change in their approval status and the appeals procedure.

- 17.11 Decisions of the review are recorded on the case files maintained by link workers and notified to the relevant child and family social worker/s. Any relevant comments or objections from the foster carers are included and a written copy of the decisions is given to foster carers.
- 17.12 Additional reviews are held following assessments and/or investigations of abuse or neglect, serious complaints, or in other circumstances where, in the view of the foster care committee, the child and family social worker, the link worker or the foster carer, one is warranted.
- 17.13 Foster care committees are notified of the outcome of reviews.

## SECTION THREE

### THE HEALTH BOARDS

#### EFFECTIVE POLICIES

# 18

*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.*

#### CRITERIA

- 18.1 Health boards maintain a panel, or panels, of approved persons who are willing to act as foster carers (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 5(1)*).
- 18.2 Health boards have a plan for the development and delivery of a range of foster care services for all children who require such services. The plan takes account of the unique characteristics of relative foster care.
- 18.3 Health boards consult with interested parties when planning the development and delivery of services.
- 18.4 Health board policies and procedures promote a partnership approach to the care of children, involving them, in accordance with their age, stage of development and individual needs, their families, foster carers and professionals employed by health boards and other agencies in the development and delivery of services.
- 18.5 Copies of health boards' plans and policies are available on request to all interested parties.
- 18.6 Health boards have sufficient dedicated foster care teams to deliver services at a local level.
- 18.7 Health boards review their plans and policies in light of changing needs, new research, inspection findings and practice developments to ensure that they remain up-to-date and relevant to the changing needs of children in care.
- 18.8 Health boards advocate for and raise awareness of the particular needs of children in foster care with other agencies involved in their welfare, especially those responsible for housing, education and social welfare.

- 18.9 Health boards that place children in other health boards' areas retain responsibility for the care of the children unless there is a formal written agreement to transfer the case to the health board in whose area the foster carers reside.
- 18.10 Health boards have arrangements with other health boards to ensure access for their foster carers to ongoing training and support within the geographic area in which the foster carers reside. Initial training related to the assessment process is the responsibility of the placing board.
- 18.11 Health boards have protocols for the transfer of cases to other health boards.
- 18.12 There are inter health board protocols to cover situations where one health board has responsibility for the care of children who are fostered by carers who receive support or other services from another health board.

## MANAGEMENT AND MONITORING OF FOSTER CARE SERVICES

# 19

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

### CRITERIA

- 19.1 Health boards have management systems in place to ensure that they deliver a high quality foster care service.
- 19.2 Health boards have systems in place to ensure that resources are matched to the needs of children who require out-of-home placement and provide a range of services including residential care, foster care and supported lodgings.
- 19.3 Health boards have monitoring and quality assurance systems in place that are separate from the line management structures for foster care services:
- to ensure compliance with statutory requirements and standards;
  - to ensure consistency and equity in relation to the quality of service across all of their community care areas;
  - to collate information on complaints about foster care services;
  - to take action as appropriate.
- 19.4 Managers ensure that the roles and responsibilities of relevant staff are clearly defined and understood by all relevant parties.
- 19.5 Health boards have effective policies and procedures for dealing in a timely way with complaints, allegations and other disciplinary issues in relation to staff and with staff grievances.
- 19.6 Health boards maintain a register of all children in foster care in compliance with statutory requirements (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part IV, Article 12* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part IV, Article 12*).
- 19.7 Health boards have information systems that provide relevant up-to-date information on the population of their region, its cultural, ethnic and religious characteristics and the number of children with disabilities, in order to facilitate planning and evaluation of their foster care services.

- 19.8 Health boards have systems in place for gathering and analysing information about their foster care services to enable them to monitor the number and type of available foster placements and the level of unmet need. The systems also gather information on foster care reviews, foster care placement breakdowns, children awaiting foster placements in other care arrangements, complaints and allegations.
- 19.9 Health boards ensure that there are a sufficient number of social workers employed to undertake the duties of the child and family social worker and link worker in compliance with statutory regulations (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part IV, Article 17* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part IV, Article 17*). They make contingency plans for dealing with situations where a child's allocated child and family social worker is unavailable for an extended period.
- 19.10 Health boards have structures in place to ensure:
- the preparation and implementation of assessments, care plans and care plan reviews for children in foster care;
  - the preparation and implementation of recruitment, assessments, approvals and reviews of foster carers;
  - the implementation of the foster care training strategy.
- 19.11 Health boards, when contracting fostering services to other agencies, enter into a service agreement with the agency that specifies the service to be offered and the monitoring arrangements to ensure compliance. (See also Standard 24)
- 19.12 As part of their annual *Adequacy of the Child Care and Family Support Services (Section 8, Child Care Act 1991)* report, health boards report on all aspects of their foster care services including: recruitment and retention of foster carers; the number of placements made; the number of children in need of placements; the appropriateness of current placements; representations and complaints in relation to foster care services, the procedures followed in resolving these and the outcomes achieved.

## TRAINING AND QUALIFICATIONS

# 20

*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.*

### CRITERIA

- 20.1 Health boards recruit staff with the skills, knowledge, qualifications, experience and suitability required to deliver a high quality foster care service.
- 20.2 There are job descriptions for members of fostering teams that clearly define their roles and responsibilities.
- 20.3 Staff training and development plans are implemented that include induction, in-service and post-qualifying training and the need for regular, formal supervision. The plans are evaluated and updated at regular intervals to remain relevant to the needs of the service providers and the demands on the foster care service.
- 20.4 Child and family social workers and link workers attend joint training programmes with foster carers.
- 20.5 There are systems in place to identify the developmental and training needs of all those involved in delivering the foster care service.

## RECRUITMENT AND RETENTION OF AN APPROPRIATE RANGE OF FOSTER CARERS

# 21

*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.*

### CRITERIA

- 21.1 Health boards have recruitment and retention strategies that relate to the needs of children who require foster placements. They carry out periodic profiles of the existing panel of foster carers, identify gaps in the service and recruit to meet the assessed shortfall.
- 21.2 Health boards' recruitment strategies include agreed procedures for investigating the availability of relatives as potential carers for each child in need of placement.
- 21.3 Health boards' recruitment strategies are informed by the priority given to placing children in their local community whenever this is consistent with meeting the children's assessed needs.
- 21.4 A range of recruitment methods and retention strategies is employed to attract and retain as large a number of foster carers as possible.
- 21.5 In order to give foster care applicants a realistic view of what is expected of them, recruitment campaigns run by health boards include experienced foster carers and, where possible, those with an experience of being fostered.
- 21.6 Health boards ensure that information on fostering is readily available to interested parties. Enquiries are acknowledged as soon as possible, but not later than one week after being received. Response times are monitored to ensure that applicants are not lost through failure to respond promptly.
- 21.7 Health boards regularly evaluate their recruitment campaigns and retention strategies in order to assess their efficacy and effectiveness.
- 21.8 Link workers organise exit interviews for foster carers who leave the service and the health board uses the information gained to inform its approach to the training, support, supervision, recruitment and retention of foster carers.
- 21.9 Health boards regularly review data and research on recruitment and retention and the levels of support required to attract and retain foster carers.



## SPECIAL FOSTER CARE

# 22

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

### CRITERIA

- 22.1 The standards and criteria that apply to foster care also apply to special foster care services. Health boards have, in addition, policies and procedures to support the care provided to the particular needs of children with serious behavioural difficulties.
- 22.2 A multidisciplinary assessment is completed on all children who are considered to be in need of special foster care. Children in need of special foster care are those whose behaviour is such that it poses a real and substantial risk to their health, safety, development or welfare and in the view of the board may require special care, having regard to the provisions of the Children Act, 2001.
- 22.3 Health boards ensure that only persons who are specifically trained and skilled foster carers and those with relevant experience provide special foster care. Health boards ensure that there is at least one full time carer available in each placement.
- 22.4 Ongoing appropriate training, in accordance with best practice, is mandatory for carers who provide special foster care.
- 22.5 Special foster carers are provided with agreed regular and emergency respite breaks.
- 22.6 The child's care plan identifies additional supports required for the placement and the health board ensures that these are provided.
- 22.7 The appropriate education service is provided to children in special foster care.

## THE FOSTER CARE COMMITTEE

# 23

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

### CRITERIA

- 23.1 The foster care committee's terms of reference stress a primary responsibility to act in the best interests of children placed in foster care by health boards.
- 23.2 Foster care committees:
- consider the assessment reports for foster care applicants;
  - recommend to health boards whether or not to put the applicants' names on their panel of foster carers;
  - receive notification of the outcome of foster carers' reviews;
  - recommend endorsement or review of their status;
  - approve long-term placements planned for a duration of at least 6 months (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Article 5 (3)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Article 5 (2)*).
- 23.3 Health boards decide whether to act on their foster care committees' recommendations and inform relevant parties accordingly.
- 23.4 Committees are made up of people with an expertise in child welfare, including some who have significant training or experience of foster care and may include one or more persons who are not officers of the health board (*Child Care (Placement of Children in Foster Care) Regulations 1995, Part III, Articles 5 (4) and 5(5)* and *Child Care (Placement of Children with Relatives) Regulations 1995, Part III, Articles 5 (3) and 5(4)*). Committees include at least one person who is a foster carer.
- 23.5 Committee members are subject to Garda and other relevant checks in accordance with health boards' policies.
- 23.6 Committee members participate in induction and in-service training programmes to enable them to discharge their responsibilities.

- 23.7 The recommendations and decisions of foster care committees are recorded and circulated to their members and to relevant health board managers.
- 23.8 Committees have access, when required, to specialist advice to clarify any aspect of an assessment, review of a foster carer, or placement of a child.
- 23.9 Health boards provide committee members with up-to-date information on the management of their foster care services, with relevant research and inspection findings and information on best practice initiatives.
- 23.10 Health boards consult with foster care committees in the planning of their foster care services.
- 23.11 Foster care committees collectively contribute to the health boards' annual *Adequacy of the Child Care and Family Support Services* reports (Section 8, *Child Care Act, 1991*).

## PLACEMENT OF CHILDREN THROUGH NON-STATUTORY AGENCIES

# 24

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

### CRITERIA

- 24.1 Health boards have clear policies and procedures regarding the contracting out of any foster care service, or part of the service, to non-statutory agencies that comply with directions issued by the Department of Health and Children.
- 24.2 Prior to the placement of any child with a non-statutory agency the health board enters into a service agreement with the non-statutory agency that specifies the services offered and the conditions under which they are offered.
- 24.3 The health board enters into a service agreement with non-statutory agencies when it satisfies itself that the agency:
- has an appropriate management structure;
  - has sound financial procedures;
  - has appropriate policies and procedures;
  - employs a sufficient number of suitably qualified staff;
  - has suitable arrangements in place for the vetting of staff and foster carer applicants;
  - conforms to legal requirements;
  - offers a service that complies with the *Child Care Regulations (1995)* and these Standards;
  - has access to foster carers who meet the health board's own approval standards and can meet the needs of children who require a placement.
- 24.4 Non-statutory agencies providing foster care services supply the health board in whose area the foster carers reside with a regularly updated list of their foster carers.
- 24.5 Children placed by non-statutory agencies in foster homes are visited and their care is supervised by health boards' child and family social workers in accordance with best practice, irrespective of the distances involved.

- 24.6 Health boards have effective monitoring arrangements in place for ensuring ongoing compliance by the non-statutory agency with the Child Care Regulations (1995) and these Standards.

## REPRESENTATIONS AND COMPLAINTS

# 25

*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.*

**Note: This standard is to be read in conjunction with attached Guidance Note on Children's Complaints in Foster Care at Appendix 3.**

### CRITERIA

- 25.1 Health boards have procedures and guidelines for dealing with complaints and representations and copies of these procedures are given to children in an age-appropriate format, their parents and foster carers.
- 25.2 Health boards ensure that all parties involved in the foster care service are aware of their right to make a complaint.
- 25.3 Complaints procedures clearly outline the following:
- what constitutes a complaint;
  - how a child can be helped to make a complaint;
  - the procedure to be followed (steps to be taken, timescale, who investigates the complaint, where and how it is recorded, feedback to the complainant);
  - how the complainant who is unhappy with the outcome can appeal a decision.
- 25.4 Health boards have a responsibility to:
- facilitate children, their families, carers and others with a bona fide interest in their welfare to make representations and complaints;
  - inform them of their right to avail of the services of an advocate or other independent service;
  - ensure they are aware of any independent services which exist and know how to access them;
  - ensure complainants and other interested parties are heard on the matter of the complaint;

- notify the complainant and other interested parties in writing of the outcome of their complaint and of the actions taken in response to it.

25.5 Health boards' complaints procedures take account of the particular needs of people with disabilities. Health boards arrange access to translation, interpretation and communication services for those who require these services.

## APPENDIX 1

### ***GUIDANCE NOTE ON SAFEGUARDING AND CHILD PROTECTION IN FOSTER CARE***

#### **1. Dilemmas in child protection**

Child abuse and neglect can and does occur in foster care. It also happens that allegations of neglect and abuse are made which are subsequently found to be without foundation. The process of assessing these allegations can be a complex and difficult one for the child, the foster carers and their children and for those who must enquire into the allegation or concern. Health boards' primary responsibility is for the safety and welfare of the children in their care but they must also find just and humane ways of dealing with foster carers and their families about whom concerns or allegations are expressed.

It is a basic universal principle of child care policy and practice that in any matter concerning children their welfare is the first and paramount consideration. Health boards, therefore, must put the interests of the children in their care before those of foster carers. Foster carers against whom allegations of neglect and/ or abuse have been made or about whom child protection concerns have been expressed have a right to be treated in accordance with the principles of natural justice. This means that foster carers should be heard on the matters of the allegation or concern and that no judgement should be made until all the facts are known. However, it is in the nature of child protection work that decisions must sometimes be made before all the facts are known. If health boards only acted on proven facts a situation could arise where a child continued to be abused in a foster placement, even after the expression of concern for the child's safety. Health boards must act on assessed risk. If the action taken is the removal of the child from the placement it is likely to appear as a judgement by foster carers who may argue that their right to be treated in accordance with the principles of natural justice has been violated.

#### **2. The conduct of child protection assessments**

- 2.1 Health boards may have to take immediate protective action to protect a child in foster care. However, where other actions are being considered such as informing a third party of the child protection concern, the person about whom the concern or allegation has been expressed has the right to be given a written account of the concern or allegation and a reasonable opportunity to reply. For example, if a serious allegation of abuse was made against a foster carer, a health board might well decide to remove the foster child/ren immediately. However, if there were further concerns about the foster carer's access to children in a work environment (for instance, if the foster carer was a teacher), the board must give the foster carer a written account of the allegation and an



opportunity to respond to the allegation before the board informs the foster carer's employer of the allegation.

- 2.2 Health board responses to child protection concerns and allegations should be proportionate. The child protection assessment should be conducted by skilled and experienced practitioners who focus not just on whether an incident occurred but also the context in which it occurred and who, in their recommendations, balance short term protective concerns against long term welfare ones.
- 2.3 Health board responses to child protection concerns should be timely. Allowing assessments to go on over a long period or delay in arriving at conclusions based on available information is not in the interests of children in care and is unfair to foster carers and their families.
- 2.4 Health boards should ensure that foster carers understand their child protection procedures. This should be part of their initial training and support.
- 2.5 Health boards should ensure that foster carers against whom allegations or concerns are expressed have the nature of these concerns fully explained to them, that they are given a written account of them, together with the health board plan of action, the timescales involved, the name of the person who will keep them informed of developments, the supports available to them and the complaints procedures should they wish to express dissatisfaction with the process or outcome of the board's handling of the matter.

### **3. Principles on which child protection policies and procedures in foster care should be based**

- 3.1 Health boards must put the interests of the children in foster care before any other consideration.
- 3.2 Health boards must treat foster carers fairly and respectfully.
- 3.3 In any situation where there is a real or apparent conflict between the interests of children in foster care and those of foster carers, the health board must act in the interests of the children.
- 3.4 In any situation where a board must act in a manner likely to be experienced as damaging by a foster carer or the foster carer's family, the board must act to alleviate the situation by arranging access to support services such as counselling.

### **4. Minimising risk**

Good care is safe care. A good foster care service, that is, one that complies with the requirements of the Child Care Regulations 1995 and these Standards, is

likely to have to deal with fewer child protection concerns and fewer allegations of abuse.

- 4.1 Health boards should only place children with foster carers who have undergone, or in the case of relative foster carers, are undergoing or are about to undergo a process of assessment and approval.
- 4.2 Health boards should ensure that foster carers are offered regular supervision and support by link workers and have access to such respite care, counselling and out-of-hours consultation and advice services as agreed at the time of placement.
- 4.3 Health boards should ensure that foster carers and their children, as appropriate to their age and understanding, receive training. This training should equip them to:
  - Respond to the needs of children who have experienced abuse;
  - Practice safe care in the foster home;
  - Recognise and report signs of abuse
  - Understand and respond to challenging behaviour;
  - Maintain appropriate records.
- 4.4 Health boards should carry out reviews with their foster carers. These should consider the service provided by foster carers and the service provided to foster carers by the health board and plan any necessary improvements.
- 4.5 Health boards should ensure that the expectations they have of foster carers are reasonable. That means, among other things, that foster carers must not be over-burdened by being asked to care for too many children or by being asked to care for a child whose needs they cannot reasonably be expected to meet.
- 4.6 Health boards should ensure that foster carers are helped to understand that some children who have been abused put themselves in situations where abuse can occur again and that the experience of abuse can impact on the way in which children interpret the actions of others and that, consequently, there is a likelihood that allegations of abuse may arise in foster care placements.
- 4.7 Health boards should clearly explain to foster carers that where concerns for the safety of children in foster care arise, they must act to protect the children even if sometimes those actions appear as a judgement on the foster carers and/ or their families.
- 4.8 Health boards should ensure that foster carers are given information on the background of each child placed with them. The information should include any history of abuse, concerns or allegations of abuse that have not been confirmed and information to suggest that the child has abused other children.

## 5. Safe care policies and practices

Children's rights: The rights of children in foster care should be actively promoted. Children should be given information about the foster care service and about their rights.

Information for parents: When their child is placed in foster care and where appropriate, parents should be given in writing:

- a statement of the children's rights;
- a copy of the complaints procedure;
- the name and contact number for the child's social worker and the social work manager;
- the arrangements for access and contact;
- a copy of the child's care plan and a date for the next review;
- a copy of the placement plan.

Access to children: Unless there are particular reasons not to do so, children in foster care should have undisturbed access to family members and others with a legitimate interest in their welfare.

A culture of openness: There should be a culture of openness in the foster care service. In particular:

- children should be repeatedly advised that there are a variety of people with whom they can share any concerns or worries such as parents, foster carers and social worker. A pre paid post card can be given to children to send to someone external to the service in the event that there is no one in the service that they believe they can trust;
- children should be told that any concerns that they raise will be taken seriously and dealt with appropriately;
- the anxieties and concerns of children with a history of abuse should be understood and responded to appropriately.

Rules and boundaries: Foster carers should have very clear rules and boundaries that apply to all those living in their home. They should cover issues such as privacy, entering the children's bedroom and physical contact. These rules should be discussed with each foster child.

Self care and self protection: Children in foster care should be taught the skills necessary to care for and protect themselves.

Sanctions: Health boards should have clear policies in relation to acceptable and unacceptable sanctions and ensure that foster carers understand and accept

these. Unacceptable sanctions include physical punishments, any form of punishment that demeans or humiliates a child, deprivation of food or drinks, limitations on a child's access to his or her family, denial of access to medical treatment or deprivation of liberty. Sanctions should be age appropriate, moderate and intended to mark the transgression rather than to match it in seriousness. Social workers should monitor the use of sanctions.

Unauthorised absences: Health boards should ensure that foster carers understand what they are expected to do if a child goes missing from their care

Anti bullying policies and practices: Each health board foster care service should have an anti bullying policy and advise foster carers on how to protect children in their care from being bullied. In any situation where a child is physically or sexually abused by another child both should be dealt with under child protection procedures in accordance with Children First, the national guidelines on child protection.

Babysitting arrangements: Health boards should have clear policies regarding the use of babysitters and foster carers should be expected to agree specific arrangements in advance with the board.

Recording systems: Foster carers should be trained and supported to keep good records to facilitate monitoring of care practices. There should be records of sanctions, complaints, accidents, incidents and unauthorised absences of young people.

Social work support: Children in foster care should have an allocated social worker who visits regularly and supervises their placement to ensure that standards of care are maintained.

Access to specialist services: Children in foster care should have prioritised access to specialist services.

Exit interviews: Children leaving a foster care placement should be interviewed and asked to evaluate the care they have received.

Child protection procedures: There should be procedures for dealing with concerns and allegations of abuse.

## **6. Dealing with concerns, allegations and disclosures**

- 6.1 All expressions of concern, allegations or disclosures of abuse by children must be taken seriously and acted on.
- 6.2 No person can agree to keep confidential information that they receive which suggests a risk to the safety of a child.

- 6.3 When a child discloses abuse he or she should be listened to, offered support and reassured that steps will be taken to deal with the issues raised. The child should not be interrogated but rather asked open questions to encourage him or her to say as much as he or she wishes to say.
- 6.4 Practice should be non judgmental. In particular, social workers and foster carers should avoid criticising alleged abusers. In cases of intra familial abuse, children frequently hate the abuse but not the abuser. Criticising this person only adds to the child's distress.
- 6.5 In cases where children are inclined to believe themselves responsible for the abuse it is appropriate to reassure them that they are not to blame. It is best to do this in a way that does not refer directly to the abuser.
- 6.6 Foster carers and social workers to whom disclosures are made should write them up as soon as possible. If they only jot down some notes and write up a fuller account later the original notes should be kept. They may be asked for in court. They should only record what they see and hear and avoid recording their own assumptions or interpretations.
- 6.7 Children who make disclosures should not be asked to repeat them over and over. Any assessment or investigation of alleged abuse must be carefully planned to avoid this happening.
- 6.8 After a disclosure the Garda and the child care manager are likely to be involved. Events, which may have initially unfolded quickly, may now slow down. It is vital that the child is prepared for this from an early stage. Someone, preferably the person to whom the child first makes the disclosure, should take responsibility for keeping the child informed of developments in the case. It is highly desirable that the child knows that there is one person who will support him or her through the whole process.

## **7 Child protection procedures**

**When a concern arises for the safety of a child in a foster home the following steps should be taken.**

- 7.1 A strategy for ensuring the safety of all children in the foster home should be devised by the social worker in consultation with her or his line manager and implemented immediately.
- 7.2 The social worker should:
- notify the child care manager of the allegation or concern;
  - discuss the matter, in an age-appropriate manner, with the children in foster care;

- meet with the parents of the children concerned to discuss the matter (but may need to withhold details of the allegation if disclosing them would prejudice a Garda investigation).
- 7.3 The social worker, in consultation with her or his line manager, must decide what to do in relation to the person about whom an allegation has been made or a concern expressed, taking account of agency policy and the situation at hand. If the person is a foster carer or a member of the foster carer's family, the social worker needs to decide if it is appropriate for the child/ren to remain in the placement or whether the person could be asked to leave the home temporarily pending the outcome of the assessment. If the person is another foster child and poses a risk to the safety of children in the placement then that risk has to be managed. If it is not possible or desirable to remove the child from the placement the social work department must consider what extra resources and supports can be provided to manage the situation. The social work department has a responsibility for all the children in the placement including the foster carer's own children and an alleged abuser.
- 7.4 The social worker should within three working days:
- give the foster carer a written account of the concern or allegation, unless to do so would prejudice a Garda investigation;
  - outline to the foster carer the actions that will be taken by the board and the proposed timescales;
  - name the person in the health board who will keep the foster carer informed of the progress of the assessment of the concern and of any decisions taken;
  - outline the supports available to the foster carer and her family including contact details.
- 7.5 Once the immediate protective measures have been taken decisions should be made in relation to further assessment. The child care manager will have to decide on Garda notification. If notified, the Garda may decide to conduct an investigation. The investigation should be planned carefully so as to minimise the trauma for the children involved.
- 7.6 Once the matter is notified to the child care manager the normal procedures for dealing with child protection concerns apply. These should be consistent with the national guidelines for the protection of children as set out in Children First. Where a child in a placement has abused another child, child protection procedures should be applied to both the abuser and the victim.
- 7.7 As soon as the outcome of the assessment is known and the board has decided what actions to take, these should be conveyed to the foster carer, both verbally and in written form. The implications for the foster carer (any change in status, the record on the foster carers file) should be clearly outlined. The foster carers should be clearly informed, verbally and in writing, of their right to challenge or appeal the outcome or complain about the process.

## APPENDIX 2

### ***GUIDANCE NOTE ON MEDICAL CONSENT***

Articles 16(1) and 16(2) (d) of Child Care (Placement of Children in Foster Care) Regulations, 1995 and of Child Care (Placement of Children with Relatives) Regulations, 1995:

- (1) It shall be the duty of the foster parents/relatives who are taking care of a child on behalf of a health board in accordance with these regulations to take all reasonable measures to promote the child's health, development and welfare.
- (2) Without prejudice to the generality of sub article (1) of this article, foster parents/relatives shall in particular-
  - (d) seek appropriate medical aid for the child if the child suffers from illness or injury.

1. Foster carers are entitled to administer, or consent to the administration of 'first aid' to children in their care. This would include cleaning and dressing cuts and scrapes, bandaging sprains and any other similarly routine treatment.

#### **Urgent Medical Treatment**

2. Foster carers have the capacity to consent to **urgent medical treatment**, which in the clinical judgement of the medical practitioner, is necessary in the interest of the child's welfare. In this regard, the capacity of the foster parent to consent can extend to ancillary procedures, which, while they may not be of themselves necessary to preserve the life or health of the child, are nevertheless a necessary part of the treatment of the child. For example, the application of an anaesthetic to a child before setting a broken bone or extracting a tooth.

In any event, in an emergency situation, the doctor is entitled to intervene on his/her own authority, without consent of a person in loco parentis. In considering whether the child's welfare demands that the treatment be given urgently, the child's rights to prompt medical treatment, and more generally, to have his or her welfare considered is paramount.

#### **Non Urgent Elective Procedures**

##### ***The Child in Voluntary Care***

3. In relation to children **under 16 years**, consent should be sought by health boards from the child's birth parents. If this is not forthcoming, it may be appropriate to seek directions from the court under section 47 of the Child Care Act, 1991.

4. In relation to children who are **16 years old and over**, the provisions of Section 23 of the Non Fatal Offences Against the Person Act, 1997 should be borne in mind. This section provides that a minor who has attained the age of 16 years can consent to any surgical, medical or dental treatment. There may be circumstances, either because it is in the best interest of the patient or because of a doubt the medical practitioner may have as to the competency of the child to give consent, where the consent of the child over 16 may need to be accompanied by the consent of the child's parent or guardian. If this consent from the parent or guardian is not forthcoming it may be appropriate to seek directions from the court in the matter.

A refusal of treatment by a child aged **16 years and over** does not override the consent of a parent or guardian to that treatment. However, where there is such a refusal, it may be appropriate for the health board to apply to the court for directions in the matter. If there is any doubt as to how section 23 should be applied, in relation to the particular circumstances of a case legal advice should be sought.

### Emergency Care Order or Interim Care Order

5. In relation to children who **are under 16 years of age**, the health board can seek direction from the court under section 13 (7) or section 17(4) of the Child Care Act, 1991, as appropriate. Directions can also be sought by the health board or by any person under Section 47 of the Child Care Act, 1991.
6. If a child is **16 years of age or over**, section 23 of the Non Fatal Offences Against the Person Act, 1997 will apply as set out above. If there is any doubt about the competency of the child to consent, directions should be sought from the court.

### Care Order

7. In relation to children **under the age of 16** in respect of whom a care order has been made, the health board can consent to treatment if it is in the best interests of the child. The health board should, insofar as is practicable and subject to the best interests of the child, consult with the child's birth parents or guardian. In appropriate circumstances the board may seek directions from the court in the matter.
8. In relation to children **of 16 years and over**, in respect of whom a care order has been made, the provisions of section 23 of the Non Fatal Offences Against the Persons Act, 1997 apply. If there is any doubt about the competency of the child to consent, the health board may consent to the treatment, if it is in the best interest of the child. The health board should, insofar as is practicable and subject to the best interests of the child, consult with the child's birth parents or guardian. In appropriate circumstances the board may seek directions from the court in the matter.



9. Where there is a refusal of treatment by a child of **16 years and over**, it may be appropriate for the board to apply to the court for direction in the matter.
10. Any issue relating to the health or welfare of a child should be treated in a prompt fashion. A child's condition should not be permitted to deteriorate pending the taking of any actions set out above.

**Note:** *This Guidance Note has been endorsed by the Ethics Committee of the Medical Council as being consistent with their "Guide to Ethical Conduct and Behaviour".*

## APPENDIX 3

### GUIDANCE NOTE ON CHILDREN'S COMPLAINTS IN FOSTER CARE

#### Background

These guidelines are being issued to accompany the National Standards for Foster Care Services. They are not intended to be definitive, but are issued to assist health boards in their task of developing and operating effective complaints systems. The guidelines are based on similar guidelines developed by the Social Services Inspectorate (SSI) for children in residential centres. They follow the principle that children in care should have the same entitlements whether they are in foster care or residential care.

#### What is a complaint?

As a suggested definition, a complaint is *any expression of dissatisfaction* about the quality, lack of, or refusal, of a service that the person complaining is entitled to use.

#### Who is entitled to complain?

All children receiving, or entitled to a service (or others acting on their behalf) have a right to complain. Parents and foster carers are also entitled to complain. While these guidance notes refer to children's complaints, there should also be procedures in place, based on the same set of principles, for dealing with the complaints of parents and foster carers.

#### Why have a complaints system?

A complaints system has a number of purposes, the primary one being to give meaningful expression to children's rights. This purpose only becomes effective if children know about their rights, are free to exercise them and the system is capable of giving their complaints a fair and impartial consideration. The main object of a good complaints system is to find ways of addressing children's sense of being treated unfairly.

Complaints systems provide one of the most reliable ways of finding out how well services are functioning/operating. They show that health boards, and other providers of children's foster care services, are listening to children, are open to learning from mistakes and are committed to improving the quality of the service.

An effective complaints system gives clear guidance to staff on how to deal with children's complaints, making them more confident in their work practices. Good complaints systems are synonymous with professional ethics and codes of practice and can only enhance the status of the service.

Effective complaints systems contribute towards keeping children in care safe, by giving them an active voice, and the ability to challenge decisions and actions with which they are dissatisfied. It is fundamental to good public administration for public services, including health boards, to have clear and well-publicised complaints procedures.

### What do people who complain want?

In research findings and surveys people who have complained indicate that four things would resolve complaints satisfactorily:

- for their complaint to be taken seriously;
- to be given an explanation of what went wrong;
- to receive an apology or expression of regret for what has happened to them;
- to be reassured that there will be no repeat.

In contrast, some of the reasons for their continued dissatisfaction are:

- the failure of service providers to put things right;
- the onus on them to “prove” their complaint;
- the lack of apologies from professionals or organisations;
- the apparent failure of service providers to learn from complaints.

### Guidelines for setting up and operating a complaints system

From the outset, avoiding confusion is of paramount importance. To this end, child protection issues are dealt with under procedures that comply with the requirements of Children First, National Guidelines for Protection and Welfare of Children. Staff conduct issues are dealt with through staff disciplinary procedures. Complaints can arise in relation to other issues. Whilst the three procedures could be going on simultaneously they are distinct and should not be confused.

These guidelines are based upon key principles, each of which has been emboldened.

- 1) Complaints systems for children should be developed **in full consultation with all interested parties** and integrated within any existing arrangements for handling complaints.
- 2) **The service approach to resolving complaints is generally regarded as the most user-friendly, non-adversarial and positive response.** Effectively, if a person feels that they have a complaint against a service then he or she has a sense of grievance, regardless of whatever others may think to the contrary. No

proof is required. People, including children, generally know if they are dissatisfied with a service. The central issue for the organisation is what it chooses to do about that fact. Health boards, and other providers of children's foster care services, are encouraged to approach **the handling of complaints as a positive service to children, in the exercise of their rights**. This approach relies upon health boards, and other providers of children's foster care services, treating all complaints as having been made against the service, not against any individual. This helps to de-personalise complaints and encourages the organisation, as a whole, to accept responsibility for trying to resolve them.

Ordinarily, **complaints are best resolved close to the point of service delivery**. Good practice in dealing with children's complaints encourages service providers to work on finding speedy, constructive and agreeable solutions to children's expressions of dissatisfaction. Complaints systems should recognise that a formal procedure is not the way most children choose to air a grievance. In developing complaint procedures health boards, and other providers of children's foster care services, should not assume that carrying out an investigation is the only method of handling complaints. Generally, best practice in children's complaints work guides more towards developing proactive, 'problem-solving' approaches. Often, a constructive, conciliatory, 'problem-solving' process will help resolve children's dissatisfaction, before it becomes a 'complaint'.

Evidence from practice and research indicates that children and carers prefer this approach to dealing with complaints. It can also be an effective method of resolving complaints, both in terms of achieving good outcomes and preserving relationships.

- 3) **A complaints system also needs to provide a formal procedure for investigation.** This procedure should be available at any stage of the process if requested by the child making the complaint, and as a 'safety net' for complaints that cannot be resolved by the service approach. For a complaints procedure to provide an adequate safeguard, children must have the facility to notify complaints to someone located outside of the foster carer's home. Complaints requiring investigation should include an independent element to avoid health boards, and other providers of children's foster care services, appearing to act as judges in their own cause.

Investigations that are carried out under the formal complaints procedure need to be handled with great care as these can be stressful for all concerned. The investigation process should ordinarily involve the following steps:

- i) initially, confirm the incident leading to complaint and decide if there are sufficient grounds for an investigation (*Is there prima facie evidence that the incident complained about happened or are the facts disputed?*). If it is decided not to investigate, the reasons for this should be recorded;

- ii) confirm that the complaint still stands;
  - iii) decide who should be notified that the complaint is to be investigated (*the child, parents, social worker, advocate etc.*);
  - iv) plan how the investigation will be carried out (*Who will do it? How long will they need? Who will they need to interview? What records will they need to access? etc.*);
  - v) carry out the investigation;
  - vi) consider the findings and any implications, including how these will be acted upon, and inform all interested parties, in writing, of the outcome;
  - vii) advise child of his or her right to appeal decision, if still dissatisfied.
- 4) The formal complaints procedure needs to confer a **right of appeal or to seek an independent review of the complaint**. This is because no procedure is guaranteed to always get it right and people are entitled to a second opinion.

Health boards, and other providers of children's foster care services, will need to put in place a process for hearing appeals against the outcome of complaints. This process will need to demonstrate fairness, by ensuring that the people involved in hearing appeals have not previously investigated, or made any determination about, the complaint.

- 5) **Complaints systems should be open, with sufficient information provided to children to enable them to use them.** The information should state what rights children can reasonably expect whilst in care. Arrangements for making complaints must be well publicised, accessible and easy to use.

Children can be helped to know of the existence of a complaints system, by foster carers and social workers advising them. Materials can be prepared and distributed, which explain that there is a complaints system, what it is for and how children are able to use it. These can be in the form of a leaflet, audiotape or on video. In preparing these, health boards, and other providers of children's foster care services, need to ensure that they are appropriate to the different ages, needs and backgrounds of children. In some examples of good practice children have been provided with pre-paid contact cards, which is a user-friendly method of enabling them to use a complaints system.

- 6) Arrangements for handling complaints should be transparent and **set within clear and reasonable time limits** for action. These ought to be defined in advance and be capable of being understood by any person wishing to make a complaint.

- 7) Children need support, from the outset, if they are to fully benefit from a complaints system. Primarily, children need **access to advocacy services**, which health boards, and other providers of children's foster care services, will need to develop or commission. This could be facilitated by each health board appointing a Children's Rights Officer. Consideration needs to be given, by those who design a complaints system, as to how the views of children who have an intellectual disability, sensory impairment or have special learning needs are heard and their rights asserted. For children with language and communication difficulties specialist help is likely to be required to ensure that they have equal access to any complaints system.
- 8) As a general principle, health boards, and other providers of children's foster care services, should respect the rights of children and others (foster carers, parents, social workers etc) to **confidentiality**. The integrity of the complaints system and principles of natural justice require that any information that is provided for the purpose of resolving a complaint should only be used for that purpose. Exceptions to this should be rare, but must include protecting children and the prevention of any perverting or obstructing the course of justice.
- 9) Complaint systems should be supported by regular **monitoring** to assure effectiveness and assist management in evaluating the quality of service provided. Training on handling complaints needs to be developed and provided to staff and managers.
- 10) Complaints need to be **recorded and stored by the children's social workers in a manner which facilitates access**. These records should include details of the complaint made, action taken to resolve it (including named individuals responding to it and timescales for completing set tasks), and whether the child making the complaint indicated that he or she was satisfied with the outcome. Records of complaints should be kept in order to inform practice development, monitoring and inspection.

## USEFUL REFERENCES

*The UN Convention on the Rights of the Child, 1992*

*The Child Care Act, 1991*

*The Children Act, 2001*

*The Child Care (Placement of Children in Foster Care) Regulations, 1995*

*The Child Care (Placement of Children with Relatives) Regulations, 1995*

*The Child Care (Standards in Children's Residential Centres) Regulations, 1996*

*The Adoption Act, 1988*

*The Freedom of Information Act, 1997*

*The Protection of Persons Reporting Child Abuse Act, 1998*

*The Education Act, 1998*

*Education (Welfare) Act, 2000*

*The Report of the Working Group on Foster Care, Foster Care – A Child Centred Partnership, 2001*

*Department of Health & Children, National Standards for Children's Residential Centres*

*National Foster Care Association, (UK), on behalf of the UK Joint Working Party on Foster Care, (1999) UK National Standards for Foster Care*

*Department of Health & Children, (2001) Youth Homelessness Strategy*

*Department of Health & Children, (1999) Children First, National Guidelines for the Protection and Welfare of Children*

*2002 Annual Report, Social Services Inspectorate*

*The National Children's Strategy, (2000) Our Children – Their Lives*

## GLOSSARY

**Access:** is the meeting of children in care with their families and others who are significant figures in their lives.

**Advocate:** is a person, independent of the service, who acts on behalf of, or in the interests of, the person using that service.

**After care:** is the support service provided by health boards, or other agencies, to young people who have remained in care until the age of 18 and are no longer in the care of the health board or who have left care before reaching 18 years of age.

**Assessment of a child's needs:** is a process of information gathering and analysis, carried out by a suitable and qualified professional/s, who assesses the needs of a child and makes recommendations based on his/her findings.

**Assessment of a child protection concern:** is a process of information gathering and analysis, carried out by a suitable and qualified professional/s, that is designed to assess whether there is any risk to the safety of a child and to make recommendations for his or her future care based on his/her findings.

**Care plan:** is an agreed written plan, drawn up by the child and family social worker, in accordance with the *Child Care (Placement of Children in Foster Care) Regulations 1995 (Part III, Article 11)* and *Child Care (Placement of Children with Relatives) Regulations 1995 (Part III, Article 11)*, in consultation with the child, his or her family and all those involved with his or her care, for the current and future care of the child, that is designed to meet his or her needs. It establishes short, medium and long term goals for the child and identifies the services required to attain these.

**Care plan review:** is a meeting held in accordance with the *Child Care (Placement of Children in Foster Care) Regulations 1995 (Part III, Articles 18, 19 and 20)* and *Child Care (Placement of Children with Relatives) Regulations 1995 (Part III, Articles 18, 19 and 20)* to consider and update the care plan.

**Case file:** is the written record maintained by the social work department of the health board, in accordance with the *Child Care (Placement of Children in Foster Care) Regulations 1995 (Part IV, Article 13)*, and *Child Care (Placement of Children with Relatives) Regulations 1995 (Part IV, Article 13)*, of its involvement with the child. A separate case file is maintained on the child's family.

**Child:** is a person under the age of 18 years.

**Child and family social worker:** is the social worker assigned by the health board to carry out its statutory responsibilities for the safety and welfare of a child in the care of that health board.

**Child Care Act 1991:** is the legislation that sets out the responsibilities of health boards for the care, safety, welfare and protection of children.



**Children Act 2001:** sets out responsibilities for the care, support, protection and control of juvenile offenders and further amends and extends the Child Care Act, 1991.

**Child Care Regulations, 1995:** are regulations drawn up under the Child Care Act, 1991 setting out requirements with which health boards must comply when placing children in residential care, foster care or in the care of relatives.

**Contact:** are the arrangements made in order for children to keep in touch with their families and significant others from whom they are separated.

**Contract:** is the agreement health boards make with foster carers in respect of each child placed with them in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995, Article 9 and First Schedule* and the *Child Care (Placement of Children with Relatives) Regulations, 1995, Article 9 and First Schedule*.

**Disability:** is a substantial restriction in the capacity of a person to participate in economic, social or cultural life on account of an enduring physical, sensory, learning, mental health or emotional impairment.

**Equal opportunities:** is about providing equality of access to services to all people regardless of differences of age, gender, marital status, family status, disability, religious belief, sexual orientation or membership of a cultural or ethnic group (including membership of the Travelling community).

**Family:** for the purpose of these Standards refers to parents, step-parents and siblings, including half and step siblings, grandparents, aunts, uncles and cousins, their spouses/partners and children.

**Foster care:** Children in the care of health boards who are placed with approved foster carers in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995*, and the *Child Care (Placement of Children with Relatives) Regulations, 1995*.

**Foster carer:** is a person approved by a health board, having completed a process of assessment and being placed on the board's panel of approved foster carers, to care for children in the board's care in accordance with the *Child Care (Placement of Children in Foster Care) Regulations, 1995*, and the *Child Care (Placement of Children with Relatives) Regulations, 1995* for the purposes of these Standards.

**Foster carer assessment:** is a process of information gathering and analysis, carried out by a suitable and trained professional who assesses the suitability of a foster care applicant to look after children and makes recommendations based on his/her findings.

**Foster care committee:** is a group of people, set up by a health board under the *Child Care (Placement of Children in Foster Care) Regulations 1995 (Part III, Articles 5(3), 5(4) and 5(5))* and *Child Care (Placement of Children with Relatives) Regulations 1995 (Part III, Articles 5(2), 5(3) and 5(4))*, to recommend approval of foster carers.

**Foster care panel:** is a list, maintained by the health board under the *Child Care (Placement of Children in Foster Care) Regulations 1995, (Part III, Articles 5(1) and 5(2)*, of people who are willing to act as foster carers who have been assessed and approved by the health board.

**Freedom of Information Act, 1997:** is the legislation that enables people to obtain access to information, including their own personal information, held by public bodies.

**Friend:** is any person who is not a member of the child's family with whom the child or the child's family is connected through bonds of affection.

**Guardian:** a person who has, in law, parental responsibility for a child.

**Health boards:** are the statutory agencies established under the Health Act, 1970 that have responsibility, under the Child Care Act 1991 and the Children Act 2001, for the care, protection and welfare of children, including responsibility for foster care services

**'In care':** children who have been received into the care of a health board, either by agreement with their parent/s or guardian/s or by court order, are referred to as being 'in care'.

**Induction training:** is training given to professionals and carers before they commence their duties. It is designed to assist them to carry out their responsibilities.

**In-service training:** is training provided to professionals and carers while they are discharging their duties to further enhance their capacity to carry out their responsibilities.

**Link worker:** is the social worker assigned by the health board to be primarily responsible for the support and supervision of foster carers.

**Non-statutory agency:** for the purpose of these standards non-statutory agencies are those agencies which, in accordance with the *Child Care Placement of Children in Foster Care) Regulations, 1995 (Part VI Article 24)* and *Child Care Placement of Children with Relatives) Regulations, 1995 (Part VI Article 24)*, may assist the health boards in the performance of their functions under the Regulations.

**Out of hours service:** is a service provided during evenings, weekends and public holidays when health board offices are closed to the public.

**Parent:** is the child's biological or adoptive mother or father.

**Placement:** is the arrangement between the health board and the foster or relative carer for the care of the child. It also describes where the child resides.

**Placement plan:** is an agreement between the health board, foster carers and where appropriate, parents, that sets out specific arrangements for the care of the child by the foster carers that are consistent with the care plan.

**Post qualifying training:** is accredited training provided to qualified professionals to enhance their skills, practice and expertise.

**Relative foster care:** is foster care provided by a relative or friend of a child who have completed a process of assessment and approval as relative foster carers or who have agreed to undergo such a process.

**Relative carer:** is a person who is a friend or relative of a child and who is taking care of that child on behalf of, and by agreement with a health board, having completed or, having agreed to undertake, a process of assessment and approval as a relative foster carer. The term 'relative' includes:

- a person who is a blood relative of a child;
- a person who is a spouse or partner of such a relative;
- a person who has acted in 'loco parentis' in relation to the child;
- a person with whom the child or the child's family has had a relationship prior to the child's admission to care.

**Respite care:** is short term care, provided to a child in order to support the child, his or her parent/s or foster carers by providing a break for the child and his or her primary caregivers.

**Service agreement:** is an agreement that a health board makes with a non-statutory agency for the provision of foster care services. Such an agreement sets out the conditions under which the services must be provided including compliance with statutory regulations and national standards.

**Sexual identity:** refers to aspects of the sexual development of children and young people including: their understanding of themselves as male or female; gestural and behavioural features which differentiate the sexes; and the choices they make in terms of their sexual behaviour.

**Significant event:** is any event of importance to a child either negative or positive.

**Significant other:** is a person who has played an important role in the life of a child without necessarily being a relative or friend of the child.

**Supervised access:** is the supervision of access or contact between a child and his or her parents, to ensure his or her safety and welfare.

**Supervision:** is a process that includes formal meetings between a professionally trained supervisor and a foster carer or another professional. Supervision has four functions: support for, and learning by the foster carer or professional, evaluation and review of the task being undertaken, and mediation.









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