Improving the health of looked after children in Scotland

1. Using a specialist nursing service to improve the health care of children in residential accommodation

The first of two studies reported here by Donna Hunter, Gerry McCartney, Susan Fleming and Fiona Guy investigated whether a specialist nursing service could improve the health care of 162 children in residential care in Renfrewshire, West Dunbartonshire and Argyll & Bute. It found that after the introduction of the service, the proportion of children with completed carer-held health records (BAAF health record booklets) increased from three per cent to 77 per cent; the proportion receiving a ‘pre-admission medical’ increased from 38 per cent to 48 per cent; the proportion adequately immunised increased from nine per cent to 56 per cent; the proportion with at least one outstanding medical referral decreased by at least four per cent; the number registered with a dentist increased from 14 per cent to 62 per cent and the proportion who received a ‘comprehensive health assessment’ increased from 17 per cent to 58 per cent. Thematic analysis of free text journals suggested that universal health services were much more accessible in Argyll & Bute due to well-developed inter-agency working, low numbers of children in residential care and low rates of staff turnover. In the more urban areas, the main advantage of the service was thought to be in the facilitation of interagency working. The service was received positively by residential care workers and children in residential establishments. This study suggests that the provision of a specialist nursing service can improve the health care of children in residential accommodation.

Introduction

It is recognised that children in residential care suffer from poor health outcomes both in absolute terms and relative to others (Saunders and Broad, 1997; Hill and Watkins, 2002; Philpot, 2004). Although the circumstances that have resulted in these children being cared for by local authorities are likely to be the main driver of these inequalities, it is also the case that they access health services at a disproportionately low rate compared to their health needs (Bundle, 2001; Williams et al, 2001; Hill and Watkins, 2002; Philpot, 2004). One potential route to improve the health outcomes of this group is to enhance the accessibility and quality of services provided for them (Meltzer, 2000; Hill and Watkins, 2002). This study was an attempt to investigate whether the introduction of a specialist nursing service could help meet the unmet health needs of children in residential care in West Dunbartonshire, Renfrewshire and Argyll & Bute (in West Central Scotland), as has been tried elsewhere (Hill et al, 2002). Renfrewshire has two specialised residential centres (the Kibble school and the Good Shepherd centre) that provide a specialist service for local authorities across Scotland. The study was funded by ‘Unmet Health Needs Fund’ monies from the Scottish Executive.

Methods

This study was a service evaluation using data collection before and after the introduction of a specialist nursing service. It took place in all child care units in Renfrewshire, West Dunbartonshire and Argyll & Bute. All of the children in residential care in these areas between August 2006 and March 2007 were included in the study. The vast majority of service users resided within Renfrewshire (n = 127 pre-
intervention; n = 125 post-intervention), with West Dunbartonshire (n = 21 pre- intervention; n = 13 post-intervention) and Argyll & Bute (n = 14 pre-intervention; n = 14 post intervention) contributing similar numbers of service users.

The specialist nursing service comprised a research project manager, three whole-time-equivalent G-grade nurses and a clerical support officer. An existing specialist nurse who already worked within Renfrewshire in the residential care units worked alongside the project staff. Each nurse was responsible for:

- promoting the existence of the service within their designated locality;
- mapping existing service provision for children in residential care;
- responding to health-related requests from service users within their locality;
- providing health promotion advice and activities for children in residential care, foster carers and residential care home staff;
- liaising with health professionals and social care providers to ensure the health needs of the children were being met;
- highlighting locality-specific issues relating to health care needs;
- ensuring that the standard health recommendations were adhered to and that relevant documentation was complete;
- gathering evaluation data before and after the introduction of the service.

The project staff were also responsible for liaising with the local NHS IT department to create a password protected database containing the health information of the children in residential care within the study area.

The main outcome measures of the study were the proportion of children in residential care:

1. with carer-held health records (also known as BAAF health record booklets);
2. with complete and up-to-date carer-held health records;
3. receiving ‘reception into care’ medicals;
4. with all age-appropriate immunisations;
5. who had defaulted on attending an outstanding medical referral;
6. were registered with a dentist;
7. attended six-monthly dental check-ups;
8. had untreated dental problems;
9. with up-to-date health assessments (comprehensive medicals) using BAAF forms;
10. whose health needs had been reported to the appropriate key (social) worker.

Within the former NHS Argyll & Clyde, the BAAF health record booklet is issued (by social work departments) to every child (originally from within Argyll & Clyde) when the young person is taken into care, and every health appointment and all previous medical history should be documented therein. The BAAF booklets are used to aid the continuity of medical information for carers and health professionals. The booklet should be held by the carer and should accompany the child/young person throughout any placement moves. Young people should have access to it and, when they are assessed as being capable of understanding the medical issues, may elect to keep personal care of the document. A revised version was launched in March 2008.

A BAAF health record booklet (from now on referred to as BAAF book) is considered ‘complete and up to date’ if all verifiable health information relating to each specified procedure or practice has been entered. Certain information cannot always be verified or completed retrospectively (eg details on the background tear-off slip indicating the reasons why the child has been taken into residential care, or completion of
centile charts) and therefore that section cannot be ‘completed’. Only information verifiable prospectively was included in the post-intervention results.

In addition to the main outcome measures, there were a number of further measures used to assist with the evaluation of the service. These comprised the journals kept by the nurses during the study, a questionnaire completed by residential care workers and an evaluation of the health promotion sessions by the children.

**Results**

One-hundred-and-sixty-two children were in residential care in the study area during the first data collection. This decreased to 152 children eight months later at the time of the second data collection. No patient identifiable data were collected in compliance with the ethics committee recommendations. This therefore precluded an accurate assessment of the number of children who had data collected on both occasions, but it is estimated that over 90 per cent of the children featured in both the baseline and post-intervention data collection. This also means that no demographic details of the children can be presented. The results for the main outcome measures are shown in Table 1.

No data were obtainable for the proportion of children who had either attended the dentist in the previous six months or who had outstanding dental problems requiring attention.

Further analysis of the BAAF books revealed the parts that were most likely to be completed (Table 2).

In addition to the main outcome measures, the journals completed by each nurse over the course of the study were thematically analysed. Four main themes emerged from this exercise. The first was that all mainstream health services in Argyll & Bute (the most rural area in the study) were readily accessed by the children in residential care within this locality. Several factors were identified that may have contributed to this. These included the small number of children in residential care, a high level of interagency working and co-operation (partly related to smaller and tighter networks of health and social care professionals) and low rates of staff turnover.

A second theme to emerge from the journals was that the success of the specialist nursing service was dependent on its ability to facilitate interagency working among care partners by becoming a ‘health-advocate’ for the children. A further theme was that ‘professional boundaries’ could prevent effective interagency working because each profession involved in the care of children in residential care has its own defined remit. This means that the needs of children can often fall between responsibilities and be seen as ‘somebody else’s job’. The fourth and final theme arising from the journals was that the BAAF books were rarely complete and up to date. This situation was thought to be perpetuated by the re-

<table>
<thead>
<tr>
<th>Evaluation measure</th>
<th>Pre-intervention % of sample (n = 162)</th>
<th>Post-intervention % of sample (n = 152)</th>
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<tbody>
<tr>
<td>With BAAF books</td>
<td>84%</td>
<td>77%</td>
</tr>
<tr>
<td>With up-to-date and complete BAAF books</td>
<td>3%</td>
<td>77%</td>
</tr>
<tr>
<td>Received a pre-admission medical</td>
<td>38%</td>
<td>48%</td>
</tr>
<tr>
<td>With all age-appropriate immunisations</td>
<td>9%</td>
<td>56%</td>
</tr>
<tr>
<td>At least one outstanding medical referral that had not been taken up</td>
<td>≥27%</td>
<td>≤23%</td>
</tr>
<tr>
<td>Registered with a dentist</td>
<td>14%</td>
<td>63%</td>
</tr>
<tr>
<td>With an up-to-date BAAF health assessment (comprehensive medical)</td>
<td>17%</td>
<td>59%</td>
</tr>
<tr>
<td>Medical needs reported to (key) social worker</td>
<td>unknown</td>
<td>100%</td>
</tr>
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</table>
issuing of blank books with each re-entry to the care system. This means that all previous documentation is lost and the motivation to keep such a record decreases when it is possible that it will only be in use for a limited period. This is explored further in the accompanying qualitative article.

Twelve health promotion sessions were offered by the nurses during the study:

1. drugs and alcohol;
2. sexual health;
3. personal hygiene;
4. diet and exercise;
5. looking after your teeth and gums;
6. giving up smoking;
7. relationships and how you feel about yourself;
8. first aid;
9. accessing health care services;
10. parenting and baby care;
11. self-harming;
12. and getting jags (injections).

The attendance of sessions and feedback from the participants is shown in Table 3. Forty-four children (15 males and 29 females) returned completed evaluation scoring wheels with representation from each of the local authority areas. At least 29 per cent of the children therefore attended at least one health promotion session. The table shows that most children who attended the sessions and provided feedback found them either quite helpful or very helpful. It also reveals that the feedback was provided mostly by females, although it is not known if this is representative of the attendees at the sessions. The most popular sessions (if the feedback returns are representative) were on drugs and alcohol, diet and exercise, giving up smoking and sexual health, with only a few children providing judgements on the sessions on self-harming and getting jags (injections).

**Discussion**

Many of the key objectives of the study sought to facilitate information-sharing between agencies, in line with the recommendations contained within *Getting it Right for Every Child* (Scottish Executive, 2006). The BAAF forms are a key component of the information-sharing process, providing relevant health information to service providers, carers and indeed the children themselves, although this view is not shared by all of those working with children in residential care. It is clear that residential care workers and most health workers are not routinely utilising this common repository for health information, and there remain numerous cultural and practical barriers to this being resolved. Although 84 per cent of children in residential care homes had BAAF books on commencement of the

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Completed sections of the BAAF book</th>
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<tbody>
<tr>
<td>Section of BAAF book</td>
<td>Pre-intervention % of sample (n = 136)</td>
</tr>
<tr>
<td>Consent for medical treatment</td>
<td>61%</td>
</tr>
<tr>
<td>Personal details</td>
<td>25%</td>
</tr>
<tr>
<td>Background report tear-off slip</td>
<td>9%</td>
</tr>
<tr>
<td>Centile chart</td>
<td>29%</td>
</tr>
<tr>
<td>Eyes (registered with an optician and received at least one eye test)</td>
<td>15%</td>
</tr>
<tr>
<td>Hearing (standard hearing tests conducted as part of comprehensive medical)</td>
<td>unknown</td>
</tr>
</tbody>
</table>
pilot project, only three per cent of them had books that were complete and up to date. On completion of the pilot project, a slightly lower percentage of children had BAAF books, but of those who did all were complete and up to date. The reduction in the number of children with BAAF books post-intervention can best be explained by ‘traffic’ through the care system (ie ‘new’ children who had not yet been issued with BAAF health records or who may have come from a local authority not issuing them).

The difficulties for NHS staff attempting to engage with foster carers through social work departments also emerged from the study. It remains to be seen what impact the creation of joint health and social care structures (Community Health Partnerships) will have on interagency working/co-operation.

The positive impact of the specialist nursing service was much greater in the urban areas covered by the study where the networks between social care and health professionals are more complex and impersonal. This contrasts with the rural centres where universal health services were found to be effective in meeting the needs of the children.

Nevertheless, the study suggests that in the urban areas the nurses managed to overcome the organisational barriers to health care access and acted as health care co-ordinators for the children. The nurses also provided impetus for a health agenda to be pursued, a feature that was missing in the urban centres prior to their arrival.

It is important to stress that this study is limited by its non-experimental design (ie it did not have control groups where there was no nursing service). In addition, it is vulnerable to the Hawthorne effect where the documentation of an effect is likely to be enhanced by the presence of researchers/project staff (Heath et al, 2007). The short duration of the study and the lack of non-process outcome measures also limit the conclusions that can be drawn from it.

**Conclusions**

In the residential homes in Renfrewshire and West Dunbartonshire the introduction of a specialist nursing service improved the documented access to...
health services for children in residential care. The systematic monitoring of health progress by nursing staff also shows signs of being an effective means to health improvement in this group.

This study indicates that there is a need for a review of the practice of recording and sharing health information between agencies, areas and different parts of the NHS.

References

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Saunders L and Broad B, The Health Needs of Young People Leaving Care, Leicester: De Montfort University, 1997

Scottish Executive, Consultation on the draft Children’s Services (Scotland) Bill Consultation, which is intended to support the implementation of Getting it Right for Every Child, Edinburgh: Scottish Executive, 2006

2. The views of residential care workers on the promotion of health and well-being of the children they care for

A lack of communication between social and health care staff has been recognised as one of the main obstacles in meeting the health needs of this group. The previous study of the introduction of a specialist nursing service in the west of Scotland showed that the rates of documentation and information-sharing between health and social care staff remain low but that a specialist nursing service could improve this. This article explores the reasons for the poor rates of information sharing and documentation by interviewing residential care workers (RCWs) and so may offer an explanation of why a specialist nursing service could help. The first theme to emerge was the conflict RCWs face between their corporate parent and health improvement roles. The need to protect the child from distress and the importance of maintaining a relationship with the child were suggested as important reasons for not promoting health interventions. Others included a lack of financial, training and staffing resources. The second theme was the difficulties involved in using the BAAF health record. There was seen to be a duplication of documentation between residential unit, health and other records and there were numerous examples of a new record being used when a child moves instead of the previous record being re-opened. Stigma experienced by the child using the record and a lack of understanding among health care professionals were also cited as reasons for the record going unused. The last theme concerned the barriers within the health service for children in residential care. This particularly referred to the inflexibility of the appointments systems in both primary and secondary care.

Introduction
It has been recognised that the sharing of information between professionals involved in the care of children in residential care is sporadic and that this remains a barrier to access to health services for this group (Residential Care Health Project, 2004, p 73). The accompanying study identified that the standard documentation (BAAF forms) designed to facilitate information-sharing was not routinely utilised by residential care workers (RCWs), although this improved following the introduction of a specialist nursing service. This qualitative study sought to explore why this shared documentation was not used routinely and the perceptions of RCWs in their role of health improvement. It was part of a Master of Public Health Degree being undertaken by the research project manager.

Methods
The development of the research question, the underpinning research strategy and the rationale for the study design are presented separately for purposes of clarity. In practice, these were not discrete issues but instead evolved as part of the exploratory process that defined the boundaries for the research.

The researchers had been involved in the evaluation of the introduction of a specialist nursing service for children in residential care and this stimulated the question, ‘What are residential care workers’ views and opinions around the health and well-being of accommodated children?’ The use of semi-structured face-to-face interviews was selected as a pragmatic method to answer this question.

The perspective adopted for the study was that RCWs are not immune to the cultural, social and political context in which they exist and that this context can affect the support they are able to give to children in their care (Bowling, 2002). It was also built upon the presumption that research outputs are, by necessity, subjectively interpreted and experienced, both by the RCWs and researchers. This dictated a qualitative research design based on a detailed study of social interactions and processes, contextualised in terms of applying theoretical, evidence-based knowledge in practice.

Twelve RCWs were recruited for the study from children’s units within the west of Scotland where the specialised nursing service for children in residential care had been introduced. A researcher attended a meeting of social work...
department managers to discuss the study proposal. These managers then distributed participant information sheets to RCWs in the children’s units and advised them that the first 12 to respond would be chosen for the study.

A semi-structured interview schedule that aimed to construct rather than simply extract knowledge was developed. This involved incorporating questions that focused on specific experiences. When constructing the questions, an awareness of face validity, language and shared meaning with the RCWs was sought. The set questions for the interviews were as follows:

- How long have you been a residential care worker?
- In which type of unit do you work?
- Have you received any specific child health training?
- What do you understand by ‘child health’?
- What role do you feel you play in the health of accommodated children?
- Do you have regular contact with health professionals?
- Where do you find up-to-date health information?
- When a child attends a medical appointment, do you take the BAAF health record booklet (BAAF book)?
- In your opinion, who is the main person responsible for the BAAF book?
- Have you received any training regarding documenting information in the book?
- Do you feel the book is useful in relation to the overall health of the child?
- Is there anything you would like to change about the BAAF book?
- What happens to the book when the child leaves the unit?
- Are there any other comments you would like to make about the book?

Two pilot interviews were undertaken to assess the appropriateness of the interview schedule, to practise interview skills and data generation, and to ensure the quality of recordings. These interviews were also conducted with two social care workers not routinely involved in child health and health documentation. Both gave valuable feedback on the interview schedule and technique. The same researcher did all the interviews. A conscious decision was made to seek neutrality, despite this researcher coming from a health background, and the aim was to have findings dictated by the respondents and not the perceptions or motivations of the interviewer. Everyone who had chosen to take part was given full information about the study and informed consent was obtained prior to interview. Interviews lasted between 20 and 45 minutes. Emergent issues were documented immediately following each one.

Formal analysis by a single researcher was not undertaken until completion of all the interviews and transcription. The transcripts were checked for consistency and accuracy with data coded manually. An initial literal reading of the data was then carried out, analysing each transcription separately and developing matrices that described what each residential care worker was and was not saying. There followed an interpretive reading establishing the most common themes from these matrices, along with reference quotations.

**Results**

Twelve interviews were conducted between 5 and 14 February 2007, with eight female and four male RCWs representing a spread of experience and seniority (Table 1). Staff were also spread between residential schools, transitional units and children’s units.

**Perception of health and well-being**

Participants were initially asked to provide details around their perceptions of the health and well-being of children in residential care in relation to their own role. The RCWs unanimously
agreed that the health of the children was important to them and all stressed the importance of mental health. Some mentioned a recent course provided by Young Minds on ways of promoting positive mental health and resilience which they had attended.

Two participants added the caveat:

Yes, I know health is important but most of the young people are between ten and 16 years of age and if there is something wrong they will come and tell us. I don’t go looking for problems. (RCW 2)

Health is definitely important but apart from making sure the young person is clean and fed properly, I don’t really think their health is part of my job unless they are ill and then I will make an appointment with the GP. (RCW 4)

Health education
Health was never proactively discussed with the children. Two of the workers raised concerns regarding the children missing out on health education at school because of poor attendance rates, but felt that they did not have the knowledge required to address this. This was described as follows:

This is their home and I feel health things should be discussed with their doctor or in health talks at school. (RCW 4)

I suppose our health talks are more kind of reactive, like if someone is caught smoking, we’ll talk to them about the danger to their health, but if someone comes in drunk I’d be stressing the dangerous situation they could get into, especially the girls, you know getting raped or pregnant – I wouldn’t talk about damaging their liver or anything, they just wouldn’t be interested. (RCW 6)

Four residential care workers identified protecting children from distress as a reason not to persist with a health appointment or health promoting behaviour:

I know jags and stuff should be up to date, but when there’s other things going on in their lives, you know, like their parents miss a contact visit, or they are in a bad place in their heads, aggressive or emotional, medicinals don’t seem that important. I think it’s my job to cancel that appointment and focus on what is important to the young person at the time. (RCW 7)

Food and obese kids are in the media all the time and we do try to give healthy choices, but it’s hard. If they haven’t eaten healthily at home, eating like chicken nuggets and chips all the time, I think it’s cruel to make them eat fruit and vegetables and things they don’t like when they are already distressed. (RCW 6)

Smoking in the units is banned now and we all have to go outside, but if consent is given by the social worker or the parent the child can smoke. We do try to stop the young people smoking in the unit but if a young person is upset I reckon it’s better to sit down and have a ciggy with them than let them go to their room and self-harm. (RCW 1)

This isn’t a hospital or a school environment. Yes, we want what is best for the young people and we try very hard to improve their outcomes across the board but we can’t continually push them. I think we sometimes forget it is supposed to be their home. (RCW 6)

The residential care workers were asked to reflect on two areas that could make the children healthier and how they

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Table 1
The distribution of experience and seniority in interviewees (n = 12)

<table>
<thead>
<tr>
<th>Years of practice</th>
<th>0–5</th>
<th>6–10</th>
<th>11–15</th>
<th>16–20</th>
<th>21+</th>
</tr>
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<tbody>
<tr>
<td>Unit manager</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deputy unit manager</td>
<td>1</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Non-management residential care worker (RCW)</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of participants</td>
<td>6</td>
<td>5</td>
<td>1</td>
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could support this. Exercise emerged as a common theme:

I’m really into keep fit and going to the gym and I’d like to see the young people exercise more. We know schools are doing less PE and it’s up to us to motivate them. I’d be happy to do some keep fit classes in the units if the council allowed it. (RCW 12)

The young people need to exercise more. At my daughter’s school they have a walk to school group, which I think is great. None of our young people can walk to school though. We try to keep them in their own schools if possible so all of our young people have to have taxis there and back. There’s just no way round it. (RCW 9)

Levels of staffing were thought not to be conducive to children attending a variety of activities and the cost of attending clubs could be prohibitive:

A lot of our young people have low self-esteem and they say exercise lifts your mood, so I’d like to support more exercise. It’s good for their weight too. It’s difficult though – there’s only two carers on each shift so, say someone wants to go to karate, it means there’s only one adult left in the unit and if someone kicks off it’s really difficult. (RCW 4)

Of the 12 participants interviewed for this study, only one felt it was not part of their job description to provide guidance on health issues:

I would love to know more about health issues. As a parent myself, I talk to my own children about healthy eating and keeping away from drugs and things like that, but I get this information from the media not from like a proper source. That’s OK because I know my kids are getting it at school and I’m just kind of backing it up, but the young people in the unit have usually missed a lot of schooling, so I feel I should be giving them information that is definitely right. (RCW 5)

We all have to do this SVQ qualification for working in the units. I did it two years ago and most of my colleagues have too. We received no input from health. (RCW 6)

We have one first-aider, but that worker obviously isn’t always on a shift, so some practical advice would be useful; someone coming into the units would be great as it is hard for staff to get away. (RCW 9)

Use of the BAAF health record

It was found in the previous study that the BAAF health record for children in residential care is sometimes absent and very few are complete. The views of the RCWs give us some insight into the reasons for this:

We tend to write in our own records. I think it’s a lot of duplication and we just don’t have time. To me a lot of the information isn’t relevant. Things like immunisations, they should get them when they are babies, so again I think it’s a waste of time trying to find out if they are up to date. I mean when they are 14 years old, it’s way too late. You’re not going to do anything about it now. (RCW 4)

Not all the local authorities use the BAAF book. We get young people from all over, so we tend to forget about it and write in our own notes instead. (RCW 6)

Several of the residential care workers felt the BAAF health record could be useful if filled in properly but voiced reasons as to why this was not always possible:

If the books are filled in I think they probably are good, but quite often we get blank ones or don’t get one at all. Really it’s up to the social worker and health to sort it out. (RCW 1)

If the book is filled in properly it’s really useful. The clinic doctors know how to fill them in but the GPs, unless it’s the ones we always go to, don’t seem to know. (RCW 2)
The book is useful for keeping track of things but I don’t push it. A lot of our young people refuse medicals, partly because they don’t feel ill and partly because it’s one of the few things they can say no to when they come into care. If it takes me a bit of time to persuade the young person to go, I won’t take the book because often, again, it makes them feel different. No other kids their age have one. (RCW 9)

I think in principle the books are a good idea, but in practice it sometimes seems like a waste of time. When the young person leaves the unit we archive the books in the loft. If the young person comes back to this unit we will retrieve it, but if the young person is admitted to another unit, another new blank book will be issued and all the fact-finding starts over again [pause]. I know it’s daft but no one seems to be able to co-ordinate keeping things together. (RCW 12)

Other residential care workers had a different opinion, stating that the books were of value, and described the steps they took to ensure the BAAF health record was up to date. Some also added suggestions on how to make the book more user friendly:

I think the books are a good thing. If we don’t get one we keep phoning the social worker until we get one. If the information isn’t in it, we phone the social worker again and get as much information as we can. Then we start phoning around for the health information and that’s the tricky bit. (RCW 3)

We always take the book to the health appointments but depending on which GP you get, some fill it in and some don’t. Some GPs make you feel they don’t have time, so when we get back to the unit we write in ourselves, ‘attended GP’. We don’t write down why they attended in case we say something wrong. (RCW 7)

In this unit we take the book to every appointment. We have ten children in the unit and there is no way we could remember all their appointments without it. I think a few extra pages for us to write in would be useful. Like if they have a cough and we give them some medicine, we do write it in the medications log, but it would show us better how often the young person had minor problems if it was written in their own book. (RCW 8)

I think the book is a good idea, but a lot of the time you can’t read what it says. Something I would change is the front cover – it’s blue and other kids get a red one [the universal personal child health record] so it stigmatises our young people straight away. Also it’s a sort of wipe-clean cover so if anyone’s hands are greasy all the information is wiped off. (RCW 5)

Accessing health care services

Unhelpful health staff were also seen as a barrier to accessing and documenting health information:

Quite often we go with the social worker to get the children’s pre-admission medical. It can be no mean feat getting past the receptionist. The children must be seen within 48 hours and though we do try as much as possible to get the children’s own GP it is not always possible. (RCW 8)

When you say you’re not the parent, some staff won’t give you all the information. I know there are confidentiality problems but we are all on the same side. (RCW 3)

Trying to get health information is impossible. As soon as you say you’re from social work the tone of voice changes and they say they will phone back, but rarely do. (RCW 4)

‘Red tape’ and waiting times for appointments were seen as a further barrier to accessing health care:

Sometimes the young people are only with us for a relatively short time, say two to three months. If there is a health problem found, by the time the
appointment comes they would be back home. There should be some sort of fast-track system for our young people. (RCW 1)

Sometimes you need an appointment after school and they are like gold dust. The thing is we are trying to get the young people into a good pattern of going to school, so we can’t keep taking them out for appointments. (RCW 6)

It is the responsibility of the RCW to collate the health information in the BAAF health record but it can be difficult for them to access such information because of concerns about confidentiality. No workers had received training regarding the book. Only one participant felt it would be of interest:

I would like information about the immunisations. I don’t know what is due and when. We used to get the BCG at school but I think I heard on the news they don’t give it any more. See what I mean; I’m not sure and I don’t want to give the wrong information. Sometimes when we are waiting for an appointment, the young person might ask to see their book which is fine, but I can’t explain things like the growth charts. I just feel it gives the young person more confidence if you seem to know what you are doing. (RCW 3)

Discussion
Children in residential care are less likely to have come from circumstances conducive to health than the rest of the population (Brodie et al, 1997) and the care system can present barriers to children in residential care accessing health services (Butler and Payne, 1997; Residential Care Health Project, 2004).

A lack of communication between social and health care staff has been recognised as one of the main obstacles in meeting the health needs of this group. The previous study of the introduction of a specialist nursing service in the west of Scotland showed that the rates of documentation and information sharing between health and social care staff remain low but that a specialist nursing service could improve this. This article explores the reasons for the poor rates of information sharing and documentation by interviewing RCWs and so may offer an explanation of why a specialist nursing service could help.

As previously noted, the study relied on RCWs’ individual interpretation and recollection of the health support they offer. This could have led to the participants being selective in those recollections and interpretations. Furthermore, the researchers had a health background and it was recognised that this could have altered the interpretation offered by the RCWs.

Three themes emerged from the interviews: the conflicts faced by RCWs when engaged in health improvement, the difficulties involved in using the BAAF health record and the difficulties in accessing health services.

Some of the RCWs said they found it difficult to marry their role as corporate parents with a role in health improvement. It was suggested that their function was primarily to prevent distress in the children they looked after, and this might be to ‘protect’ them from health interventions such as vaccination. It was felt that any vociferous support for such interventions could jeopardise their relationship with the child. Other problems expressed in promoting health were related to the lack of staff, training and financial resources available to them.

The value of the BAAF health record was not always clear to the RCWs and there was an issue with the responsibility for maintaining the record lying with RCWs while the key players in contributing to the record were social workers and health care professionals. This duplicated the documentation used by the RCWs, social workers and health care professionals and led to a situation where no one had a vested interest in keeping it up to date. It was noted that the record can quickly become out of date if it is not used regularly. It was
also suggested that the information contained within the record can be lost if a child moves between units, with new blank records being started, thereby negating the value of a personal record that moves with the child. Some RCWs also suggested that the book was stigmatising.

Several barriers to children in residential care accessing health care services were illustrated by the RCWs. The appointments systems both in primary and secondary care was a particular issue highlighted for its inflexibility and lack of tailoring to the needs of the child. A final issue for residential care workers was the problem some health care professionals had in sharing information with them, making it difficult for follow-up to be assured.

References


Residential Care Health Project, Forgotten Children, Edinburgh: NHS Lothian, 2004

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