

# Quality is everyone's responsibility: Applying implementation science to residential child care

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## **Abstract**

With millions of children worldwide living in alternative care settings, this article applies the learning from implementation science to advance the sector's thinking around what needs to be in place to ensure consistently high-quality residential care. Building on the quality indicators identified by Farmer et al. (2017), an international review of the residential care literature (Porter et al., 2020) and focusing on smaller residential care settings, the article discusses how the eight implementation drivers within active implementation (Fixsen et al., 2005; 2019) can encourage a more nuanced, multi-dimensional understanding of what is needed to enable quality in residential child care. Greater attention to value-based recruitment of staff; the coaching of staff; the collection, analysis and use of meaningful data; and feedback loops from the practice level to engaged and adaptive leadership all emerge as areas for further attention. The article concludes by asserting that implementation science can constructively challenge the planning and delivery of residential care and, importantly, do so in a manner that recognises the different contexts, settings and environments in which residential care is provided to children and young people internationally.

## **Keywords**

Residential care, active implementation, implementation science, quality care, children's rights

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## Introduction

Millions of children worldwide continue to grow up in various forms of alternative care. While providing early support to families to prevent separation is rightly the first objective within child protection and alternative care systems worldwide, there remains a need to better understand how residential care fits within the range of options envisaged by the UN Guidelines on Alternative Care of Children (Guidelines for the Alternative Care of Children, A/RES/64/142, henceforth 'the Guidelines'). This need arises from the ongoing use of residential care worldwide, which requires us to ensure that it is 'specifically appropriate, necessary and constructive for the individual child' (UN Guidelines, para 21).

An international review of the residential childcare literature conducted by this paper's authors (Porter et al., 2020) found that there are many variations of residential care worldwide, relating to different national settings, systems, and terminologies, not always clearly distinguished in the literature. While residential care encompasses all non-family-based care, not all forms of residential care are suitable. In this article, we propose that the multiple forms of residential care can be grouped into two distinctive groupings: institutional care and (quality) residential care. Institutional care encapsulates care provided in large settings, often isolated from the broader community, housing high numbers of children, with high child to caregiver ratios, and mainly attending to children's physical needs, rather than their psychological, social, and emotional well-being and development. Residential care is more individualised and provided in smaller, 'family-like' settings, with fewer children living in these settings and low child to caregiver ratios. Such settings offer greater opportunity for stable and meaningful relationships between children and their caregivers to form, and for children to maintain connections within the wider community. We highlight this distinction as there is widespread agreement in international policy, evidence and practice that institutional care is unsuitable and needs to be phased out. Accordingly, this paper focuses on quality within residential care and the added value that implementation science can bring to ensuring quality in these settings.

Much remains to be understood about how residential care fits in the care system today, for whom it may be the most desirable care option, what factors constitute quality care, and how such quality factors can then be delivered consistently. The Porter et al. (2020) international review of 111 papers spanning data from 68 countries found that only a limited literature exists that specifically considers what constitutes quality in residential childcare. This paper therefore seeks to contribute to the wider literature by first drawing on the Farmer et al. (2017) review into quality in residential care and the quality domains they identify, before introducing and learning from a related and growing field of international social science research – namely, implementation science. In particular, we focus on how the use of the implementation drivers (Fixsen et al., 2005; 2019) can advance our knowledge of what needs to be in place to achieve and maintain quality residential care. The paper concludes by considering what implementation science offers in terms of understanding high quality practice within residential care and provides direction on priorities for future research.

In approaching our analysis, we take as a starting point considerations of what all children need to thrive, to help us understand how residential care – and the alternative care system as a whole – can support healthy development. Attending to children's specific needs, such as providing services to address early trauma and attending to the circumstances that lead children into alternative care in the first place, needs to be conducted on a foundation of what all children need, in order that residential care can be a place where children thrive.

## **Quality in residential childcare**

Farmer et al. (2017) conducted a literature review from which they proposed a framework for looking at quality. It highlights four key domains of quality within residential care: setting, staffing, safety, and treatment. A fifth domain – outcomes – was also identified but was not widely discussed or articulated. When looked at collectively, the domains identified by Farmer et al. (2017)

contribute to quality care based on enduring, loving relationships and the realisation of children's rights.

Looking at each of the quality domains individually, it is clear that setting is one of the more prominent domains discussed in policy and practice. This encompasses the physical construction of the residential setting, the connections and integration within the wider community, and the routines and rules which shape daily life and activities. Generally, the greater the extent to which these elements replicate or produce a family environment, the higher the quality achieved within this domain (Garcia-Quiroga & Hamilton-Giachritsis, 2017; Llosada-Gistau et al., 2017).

Safety is the most regulated of the domains proposed and is frequently cited where there are failings of residential care (Farmer et al., 2017). The physical safety of children and young people within residential settings is often the subject of legislative direction and may also be impacted by health and safety legislation related to workplaces or places where the state is responsible for physical safety. Aspects within the safety domain include rules and structures (Swerts et al., 2019), discipline processes (Steels & Simpson, 2017), and freedom from abuse (Sherr et al., 2017).

Conversely, staffing is less commonly considered and, where it is, often focuses on staff certification, qualifications, and turnover (Colton & Roberts, 2007; Curry et al., 2013). However, caregivers represent a critical factor in the quality of care provided within residential settings (Chernego et al., 2018; Garcia-Quiroga & Hamilton-Giachritsis, 2017; Steels & Simpson, 2017), with caregiver affect and relationships with young people, alongside more examined areas such as training (Mota et al., 2016), retention (Bailey et al., 2019), and children to caregiver ratios (Batki, 2018), all important.

Finally, the treatment domain is highlighted as a complex yet essential component of quality residential care. The high probability that children and young people will have experienced significant trauma in their lives prior to admission to residential care makes therapeutic processes essential to providing quality care (Bailey et al., 2019), and understanding and openness to trauma

informed practices has increased within the residential care sector (Galvin et al., 2020). Farmer et al. (2017) highlight treatment as the central domain of quality residential care, and indicators of quality may include using an evidence-based treatment (Gander et al., 2019), having a focus on child agency, rights, growth, and development (Hueche et al., 2019), and maintaining appropriate family-like routines (Mota et al., 2016).

## Implementation science

In light of the limited literature dedicated to quality in residential care, this paper contends that implementation science can be used to advance our knowledge of what needs to be in place to deliver quality on a consistent basis. For those readers new to implementation science, Blasé et al. (2012) define it as 'the study of factors that influence the full and effective use of innovations in practice. The goal of Implementation Science is not to answer factual questions about what is, but to determine what is required'. Implementation science can therefore address the widely experienced scenario of the knowledge of 'what works' not filtering down to practitioners or only being adopted slowly (Ghate, 2016). Within implementation science, a widely used framework to help ensure consistent, high quality delivery of innovations, practices and programmes is the drivers' framework (Fixsen et al., 2005; 2019; see Figure 1).

**Figure 1: Drivers Framework within Active Implementation**



**Source: Fixsen et al. (2019)**

Not to be confused with the drivers' diagram used within improvement methodology (Langley et al., 1996), the drivers framework consists of three clusters of infrastructural factors, attending to competency, organisational and leadership factors that the evidence finds need to be in place to implement practice as intended and achieve improved outcomes (Bertram et al., 2015; Fixsen et al., 2019). These are selection, training, coaching, systems intervention, facilitative administration, decision support data system, technical leadership, and adaptive leadership (see Figure 2). Implementation as intended is conceptualised by the term 'fidelity', with each driver contributing towards achieving fidelity, as individually and collectively the drivers are designed to ensure that the competency, organisational and leadership factors are all in place so that implementation can happen as intended. Attention to the eight drivers is also found to support the sustainability of the practice (Bertram et al., 2015; Kaye et al., 2012).

**Figure 2: The Eight Implementation Drivers**

<b>Competency Drivers</b>	
<b>Selection</b>	The goal of the selection driver is to select the 'right staff' who are ready, willing and able (Fixsen et al., 2019; Kaye et al., 2012). Acknowledging that selection may come from individuals both new and existing to the organisation (Aarons and Palinkas, 2007; Kaye et al., 2012), the selection driver requires attention to the skills, qualifications, attitudes, values and coachability of potential recruits (Bertram et al., 2015; Fixsen et al., 2019). Of these, implementation science places greater emphasis on the personal qualities of individuals, as opposed to their qualifications and employment history. Bertram et al. (2015), for example, highlight the importance of assessing for individuals' values such as compassion and empathy, and of assessing for coachability with regards to their openness to receive coaching, feedback and data. Aarons and Palinkas (2007) also highlight the importance of selecting for personal qualities, such as those who can demonstrate perseverance, flexibility and experience.

<p><b>Training</b></p>	<p>Training follows selection and its goal is to teach practitioners the knowledge, skills and abilities required to deliver the practice (Fixsen et al., 2019). In doing so, training should include adequate information to help practitioners understand why the practice is necessary and likely to be effective, as well as allow for some shared exploration and feedback in how the practice is delivered (Fixsen et al., 2009).</p> <p>Indeed, Aarons and Palinkas (2007) and Bertram et al. (2015) find that training is best delivered where it involves opportunities to practice and apply the learning as well as didactic explanation, and is provided by competent, experienced, and flexible training staff who can provide supportive, constructive feedback in a safe learning environment. The intended outcome of the training driver is for all practitioners to have a shared knowledge of the children and young people to be supported, the rationale and theory of change for the practice, the practice itself broken down to its key elements, activities and phases, and its intended child and young person outcomes (Bertram et al., 2015).</p>
<p><b>Coaching</b></p>	<p>Coaching is distinct from training and is the continual cycle of providing information, consultation, and feedback to practitioners as they implement practice changes (Fixsen et al., 2009). Through 'on the job' coaching, practitioners advance from having knowledge of a practice to being able to apply their learned skills and practice at a consistently high quality (Fixsen et al., 2019; Margolies et al., 2021). As a process, coaching should consist of direct observation of the practitioner to accurately assess and then provide feedback on their skills, delivery and judgement (Bertram et al., 2011; Burkhauser &amp; Metz, 2009). The observer (i.e., the coach) ought therefore to be an experienced practitioner who is expert in and can model the practice, can assess quality of practice, and build constructive and instructive relationships with those that they are coaching (Burkhauser &amp; Metz, 2009).</p>
<p><b>Organisational Drivers</b></p>	
<p><b>Facilitative administration</b></p>	<p>Facilitative administration focuses on the internal organisational factors that best support practitioners to practice as intended, such as practitioner caseloads and allocations, staff rotas, length of</p>

	<p>sessions with children and families, access to IT, and availability of training and coaching (Fixsen et al., 2019; Margolies et al., 2021). Sitting below the senior leadership level, facilitative administration often lies with operational managers who listen out for organisational factors that inhibit high quality practice and then act on these.</p>
<p><b>System intervention</b></p>	<p>If facilitative administration focuses on internal organisational factors, system intervention relates to an organisation’s external environment and the wider system(s) in which it operates. Given that residential childcare is part of a multi-agency children’s services system, addressing discontinuity and seeking alignment across different partners is critical (Jonson-Reid, 2011). The system intervention driver revolves around strategies for working with external systems or organisations to ensure the availability of the financial, organisational and human resources required to support implementation of practice (Fixsen et al., 2009). For example, if selection of new staff is affected by shortcomings in universities’ social work curricula, the system intervention driver would involve engaging with higher education leaders and influencing their curricula. System interventions can span local, regional, national and even international systems, meaning that some issues may be resolved quickly but others may take many years (Fixsen et al., 2019).</p>
<p><b>Decision Support Data System</b></p>	<p>A decision support data system (DSDS) is a low burden system for identifying, collecting, organising, and analysing data that are useful to the staff, coaches, managers and leadership implementing a practice (Bertram et al., 2015; Fixsen et al., 2019). Spanning process, fidelity, capacity and outcomes data (Fixsen et al., 2019), the data system needs to provide timely, accurate, and reliable data for decision-making. Indeed, for data systems to truly become DSDSs, attention is paid not only to what data is collected but also how the data is used and analysed in a timely fashion to inform decision making and improvement at the individual child and practitioner level up to the strategic leadership level (Bertram et al., 2011).</p>

**Leadership Drivers**



<p><b>Technical leadership</b></p>	<p>Technical leadership is most needed in circumstances characterised by greater certainty (Bertram et al., 2015). For example, there is agreement about both the nature of the challenge and the correct course of action, and a precise answer can be provided. In this respect, Heifetz et al. (2009) note that technical challenges may be complex, but can be addressed by current knowledge, expertise and structures.</p>
<p><b>Adaptive leadership</b></p>	<p>Adaptive leadership is most needed when there is greater uncertainty and the problems and their solutions are less clear (Fixsen et al., 2019). In these situations, Heifetz and Laurie (1997) identify the need for six broad approaches: <i>getting on the balcony</i> (to see the bigger picture), <i>identifying</i> (and understanding) <i>the adaptive challenge</i>, <i>regulating distress</i> (so striking the delicate balance between having people feel the need to change and having them feel overwhelmed by change), <i>maintaining disciplined attention</i> (with a collective, joined-up focus that overcomes diverse values, views and experiences), <i>giving the work back to the people</i> (so that all staff can assume responsibility for changes), and <i>protecting all voices</i> (as change can come from all levels in an organisation).</p>

There are examples in the literature of the drivers framework being used to good effect, particularly in the implementation of evidence-based practices in new settings (see for example Margolies et al., 2021), but this article takes a forward look by considering how the drivers' framework could help facilitate the consistent implementation of 'quality' residential care and inform stakeholders on the features to look for when assessing whether quality residential care is in place. The next section therefore discusses each of the five quality domains identified by Farmer et al. (2017) in the context of what the implementation drivers can bring to their understanding and application.

## **Implementation science's contribution to quality in residential childcare**

When we look at the components identified by Farmer et al. through an implementation frame, we can see that there are a range of drivers that need attention to facilitate the successful and long-term implementation of high-quality care. It is important to note that we are not suggesting that the activities we discuss here are 'new' or have not been attended to already. However, learning from active implementation indicates that it is not enough to look to one or two of these drivers, but rather that they all need to be in place for the desired practice to become successfully embedded in the long term.

### **Setting**

The creation of a setting which is conducive to quality care requires us to think about setting through a variety of perspectives. We need to think beyond the immediate physical space in which children and young people live, to incorporate the wider community setting and connections to it, as well as the social structure and setting, the rules and routines that govern daily life, and that contribute to creating a familial, home-like atmosphere. This wider perspective highlights the influence that a range of drivers can have on helping or hindering the development of a high-quality setting.

At first glance, the competency drivers may not appear particularly applicable to setting quality yet incorporating the social structure and community aspects highlights the importance of considering setting factors when recruiting and training staff. The right value base and approach to children and young people, risk, and rights will facilitate the creation of a positive, high quality, social setting. Staff who are dogmatic and like a high degree of control and authority are less likely to produce a family-like setting which allows children and young people to express themselves. The creation of constructive routines that provide stability and predictability for children and young people also contributes to the setting.

While staff and their shared understanding between children and young people can influence setting, often it is organisational drivers that have a direct impact on it. For example, practice and policies which heavily regulate interactions with children and young people may detract from the nurturing of strong, stable relationships and the creation of a high-quality setting. Alongside regulation, attitudes towards risk are likely to heavily influence the degree to which children and young people in residential care feel, and are facilitated to become, integrated into their communities, or able to maintain established connections, such as through school, extracurricular activities, or with their friends. Attending out-of-setting activities may require greater flexibility in the hours that staff work and the activities that they are expected to be engaging in. Developing a new approach to risk which incorporates a trusting relationship with the child, and recognition that restricting opportunities to integrate into the community is a risk in itself (Duncan, 2020). These can be organisationally challenging and rules and procedures around authorisation, consents, or risk assessments (issues which might all be addressed through attention to facilitative administration drivers) are likely to limit the opportunities available to children and young people.

The quality of care can also be improved through focusing on the setting domain. Thinking about how the setting can respond to children and young people's needs can drive improvements and innovations, such as the establishment of therapeutic spaces (e.g., sensory rooms) and the opportunity for young people to express themselves (e.g., decorating personal spaces).

Leadership also has a role to play here, in acting as a champion for the values which are claimed by the setting. Children's rights represent a crucial component of care settings, and leadership which recognises and actively pursues the realisation of children and young people's rights to be involved in decisions affecting their lives, and values the autonomy of the children and young people in their care, can empower staff to embody these values, and to implement them in practice.

## **Safety**

Implementation science teaches us that recognising and understanding the 'invisible infrastructure', the complex system within which organisations operate and implement programmes, is crucial for programmes and innovations to be successfully implemented as intended, and sustainably so over time. It also stresses the importance of co-creation, the desirability of working together alongside policy makers and practitioners to harness their respective knowledge and know-how (Ghate, 2016).

This is particularly relevant when considering the domain of safety, which as noted earlier, is the most regulated one, requiring services to abide by policies and legislation, as well as to rules and regulations set at the organisational level. Keeping in mind what is good and necessary for all children and young people and what conditions need to be in place for their healthy development can help us think about safety and how it is ensured in a residential care environment in such a way as to move away from a focus on risk mitigation towards a focus on all relational aspects, between children and caregivers, as well as among children and young people. This builds on the notion that stable, loving relationships and healthy routines are at the heart of quality residential care, so safety can be ensured by putting arrangements in place that are based on trusting relationships rather than over-relying on rigid rules and structures.

Additionally, given the importance of caregivers' expertise, values, affect, and attitudes, the question of safety needs to be pondered alongside considerations of professional autonomy and discretion. While rules and clear daily routines aimed at creating positive group climates contribute to enhanced safety and are therefore positive strategies that facilitate the delivery of quality care, (Farmer et al., 2017; Leipoldt et al., 2019) bureaucratic requirements and rules and regulations should not hinder professionals' practice.

The literature highlights the importance of a positively focussed-motivational system, and indicates how, for example, the use of humour is highly valued by children, as are positive reinforcements of good behaviour (Farmer et al., 2017). Caregivers need to be able to use their knowledge, professional skills, and judgement to be physically and emotionally available for children and deliver relational based practice. A number of implementation drivers can support in this

area: at the organisational level, both facilitative administration and leadership drivers can play a role in ensuring that practitioners are supported in their role and in delivering the practice to the best of their ability, while also allowing for a level of autonomy so that adaptations based on context can happen. The competency drivers of training and coaching are also useful in this domain, as they can help caregivers gain a solid knowledge and understanding of the practice and of the children they work with and are actively supported and encouraged to improve through coaching, observation, and feedback.

The literature highlights the importance of involving children and young people in assessing not only the quality of their care, but also their quality of life and their well-being. (Farmer et al., 2017; Llosada-Gistau et al., 2017; Swerts et al., 2019). Additionally, involving children and young people in collaborative planning, including in areas concerned with the mitigation of risk, can contribute to strengthening practice and quality of care (Johnson et al., 2017). In this domain, young people stress the importance of trusting relationships, being listened to, lack of judgement and feeling that someone cares for them as essential, as is the availability of peer support (Johnson et al., 2017). Farmer et al. also note that lesser reliance on restraint is associated with more positive longer-term outcomes. This invites us to think about co-production of care services as going beyond engagement between policy makers and practitioners, to creating and nurturing opportunities for service users (i.e., children and young people) to be actively involved in service planning and 'quality assurance'. Competency, organisational and leadership drivers can help services create opportunities for children and young people to provide their views on their care and ensure that this feedback is listened to and acted upon.

## **Staffing**

The individuals who care for children and young people in residential settings clearly have a critical role to play in ensuring that high quality care is provided. Accordingly, the quality domain of staffing is one which has previously received significant attention in terms of attending to the recruitment, training, qualifications, and retention of staff (Colton & Roberts, 2007; Curry et al.,

2013). However, below the skin of these practical components, are the less tangible qualities or opportunities that residential carers need in order to provide high-quality relationship-based care: the space to provide trauma-based care (Baker et al., 2018); the right motivation (Beckler, 2014); and the empowerment to provide individualised care (Cameron & Das, 2019). Too often, however, these elements are looked at from an individualised perspective, asking the question 'how can the residential worker provide better quality care'? Active implementation stimulates a slightly different question: 'What is needed to enable quality in the staffing domain to be achieved'?

Active implementation consequently encourages us to look beyond the more immediately relevant selection, training, and coaching drivers. These drivers remain key to quality staffing, and attention to selection on the basis of personal qualities and beliefs (Levy & Reuven, 2017) and the provision of high-quality training and coaching (Hueche et al., 2019; Baker et al. 2018) are significant factors in the provision of high-quality staffing. However, we also need to consider other organisational and leadership factors that are comparatively neglected in thinking about improving staffing. At the individual practitioner level, for example, they will be supported by facilitative administration and appropriate leadership. If quality care requires individualised approaches for each child and the opportunity to develop relationships with key individuals, then workers need not just the training and coaching to support their work, but a working environment that enables and facilitates these. Accordingly, we also need to attend to the organisational drivers to ensure successful and long-term implementation of quality in the staffing domain.

Facilitative administration might support quality staffing by providing flexible scheduling of staff to ensure that key relationships are not just possible, but actively promoted and facilitated through ensuring that shifts coincide with opportunities to spend time with the child or young person. Facilitating flexible working that allows individual children and workers to build interests, skills and hobbies together, further supporting the development of positive relationships. This includes providing staff with the permissions to provide the care that they think is necessary for each child and gives them the freedom – and protection –

to take 'risks' which may result in perceived 'failure' to support the tailored individual care for every child or young person. Reductions in paperwork, risk assessments and authorisations for activities can represent an administration striving to facilitate high quality, individualised care for all their young people.

At the organisational level, factors such as consideration of support for staff, supervision, promotion of professional self-awareness, provision of mental health benefits, adequate holiday and working conditions will help ensure that caregivers are available for the children, both physically and emotionally.

Systems intervention requires us to think beyond the individual worker, and even beyond an individual setting, to try and effect change in the ecosystem within which residential care operates. The policy drivers which influence residential care relate to national strategic aims in respect of providing care for children and young people at a national level. The development and proliferation of quality care in residential settings requires that appropriate attention is paid to developing policy which makes the space in which quality can flourish, and which rewards and promotes quality initiatives.

### **Treatment (or Therapeutic Approach)**

The fourth of the Farmer et al. (2017) quality domains is entitled 'treatment', a term that reflects that their article centred on the learning from the Teaching Family Model, which they refer to as 'a specific treatment model'. It is on this basis that Farmer et al. use 'treatment' as the fourth domain name. However, we propose using a more inclusive, non-medical and international term for the domain – namely, 'therapeutic approach'; while another option might be 'evidence based programme'. Irrespective of the name of the domain, Farmer et al. find it to be a central but complex component of quality care. The strengths, trauma and needs of each individual child needs to be assessed, the most appropriate therapeutic approach selected, and then from an implementation science perspective there needs to be firm attention to ensuring the therapeutic approach is delivered as intended.

In this context, the concept of fidelity is particularly relevant to the delivery of identified therapeutic approaches. Attention to the competency drivers will mean that staff are selected with the values and skills that align with the approach, and then have the training and support to deliver it as intended (Cameron & Das, 2019; Hurley et al., 2017). The organisational drivers ensure staff have the administrative, data, funding and policy environment that is conducive to work in (Bertram et al., 2015; Kaye et al., 2012). Leadership helps to ensure the purpose and means of delivering the therapeutic approach are articulated clearly and can then attend to and resolve any technical aspects related to the approach's implementation, which might include affirming adaptations so that individual children's needs are met within the parameters of the approach. In summary, the striving towards fidelity provides a clear focus to each of the activities within the eight drivers and, by doing so, will help achieve positive outcomes for children.

## **Outcomes**

Outcomes is the fifth quality indicator identified by Farmer et al. (2017) but one that is separated out and under-developed compared to the four other domains. By treating outcomes as distinct, Farmer et al. (2017) are reflecting the widely found disconnect in the literature between delivery and the outcomes to be achieved through delivery; very much akin to the disconnect between the desire for headline, long-term outcomes, yet little attention to shorter-term indicative measures that can help evidence whether progress towards those outcomes is being made. A key contribution that active implementation can therefore make to the design and delivery of residential care is that the collection, analysis and use of data is a core aspect of high-quality practice and service delivery. Indeed, data are not only collected for the measurement of outcomes but also for measures relating to the scale, quality of and capacity for delivery (termed 'process/inputs', 'fidelity', and 'capacity' measures respectively within active implementation). Conceptualised within active implementation as the decision support data system (DSDS) driver, this multi-faceted collection and use of data helps to ensure there is no disconnect between delivery and the measurement of the outcomes to be achieved.



While active implementation encourages the collection of data under the domains of process/input, fidelity, capacity and outcomes data, this approach does have relevance and application to the Farmer et al. (2017) quality indicators of staffing, safety, setting and treatment.

- For setting, a key measure due to the importance of small-scale, family-based settings would appear to be child to staff ratios, but other measures could extend to assessments of how nurturing a residential setting is. For example, Robinson and Brown (2016) set out an environmental checklist for residential settings to assess how space, light, smell, and other sensory elements can support or affect children and young people, and McCool (2008) and Wilson (2013) highlight the importance of assessing how settings communicate with children and young people.
- For safety, and with overlaps with staffing measures below, measures might include child-staff ratios and staff completion of mandatory training and qualifications, while observations of practice can provide managers with quality assurance as well as fidelity data.
- For staffing, process/inputs data measures might include staff recruitment, retention, sickness, absence, and vacancy levels; while fidelity measures can be taken from observations of staff practice and direct feedback from children about their experiences of the care they receive. For example, do they feel listened to? Do they feel supported? Do they feel loved?
- For treatment (or therapeutic approach), fidelity measures, such as observations of staff practice and direct feedback from children, can evidence whether practice is being delivered as intended. However, therapeutic approach can also extend beyond the quality of practice and include the capacity within a residential setting to implement a new approach. Implementation capacity measurement tools can therefore be used to assess the extent to which an implementation team is, for example, in place to embed a designated approach within a setting.

Active implementation encourages a more comprehensive and creative approach to the collection and use of data. It is an approach that extends beyond only collecting what is easily measurable (e.g., staff attendance at a training course)

to one that attends to the measurement of quality and what truly matters to children. In doing so, existing administrative data is complemented and enhanced by observational and experiential data from children and young people, staff, and coaches to collectively provide insights into staffing, setting, safety, therapeutic approach, and outcomes. As a final point however, and one relating back to the competency and leadership drivers, this approach to data does require a staff and management group that is skilled and enlightened to the value of the data in helping to inform future improvements.

## Conclusions

This paper has sought to contribute to the limited literature dedicated to what constitutes quality in residential care by considering the value that an implementation lens brings. Building on the quality domains identified by Farmer et al. (2017), the paper has sequentially discussed how the eight implementation drivers (Fixsen et al., 2005; 2019) and the concept of fidelity provide a more nuanced understanding of what is needed to enable quality in residential care. In doing so, the paper highlights the need to move beyond the more immediately tangible factors of, for example, recruitment of certificated staff, child-staff ratios, and the presence of policies and procedures, to consider in greater detail the complex environments in which residential care workers operate in. With the prompts provided by the implementation drivers, we can start to ask questions of whether the training, coaching and observations, day-to-day flexibilities and permissions, IT, data, and leadership supports are truly in place for workers that enable them to deliver high quality residential care to children on a consistent basis.

The paper also underlines some of the critical contextual factors that impact on service delivery and the ability of services, and all those that work within them, to achieve their stated goals. These include an understanding of the broader context and systems, and all the ways in which they can impact individual organisations and the services they provide. The presence of a feedback loop between practitioners, policy makers, and children, young people and families that rely on services can help ensure these are actually leading to intended

outcomes, and that policies and plans can help create and adapt child protection and alternative care systems to respond to the needs of each child.

In this respect, collection, analysis and use of meaningful data can support not only delivery of specific services, but also monitoring of progress towards targets set within national or international policy initiatives, such as the Sustainable Development Goals. Goals to eradicate poverty, ensure health and well-being for all, provide access to inclusive and equitable quality education, promote inclusive economic growth, reduce inequality, and promote peaceful, just, and inclusive societies are particularly relevant for children in out of home care, and their families and communities. Collection and analysis of meaningful data would ensure that all children are counted, including those in out of home care, and thus ensure that efforts towards leaving no one behind are truly meaningful and measurable.

The planning and delivery of residential care services for children is the lot of policy-makers and practitioners worldwide, across widely different economic, social, and cultural contexts. Implementation science helps us understand that the implementation or replication of appropriate services or programmes is not sufficient; they also need to 'function in context-sensitive ways', and adapt to local circumstances, reflecting local practical considerations or cultural preferences (Ghate, 2016). Effective practice relies on practitioners in the field making use of their own professional skills and judgement, and this is a factor leading to successful achievement of outcomes (D'Andrade, Austin & Benton, 2008 and Chambers et al. 2013, cited in Ghate, 2016.). This is particularly relevant when considering the provision of 'technical assistance' to support efforts towards reforms of child protection and alternative care systems in third countries.

Researchers have a significant role to play in the exploration of implementation and quality within residential care. While Farmer et al. (2017) provide an outline of quality, there is still a lot of work to be done to determine what aspects of each domain are the most influential, the degree to which these are inter-related, and, crucially, how quality is experienced by children and young people. Attention to rights is required in research as much as practice, and researchers

should continue to work alongside children and young people to learn about how individual quality domains and changes within them are experienced, and to develop ways of working that attend to the views, wishes, and needs of children and young people in residential care.

For practitioners, the implementation literature provides guidance in how the environment in which care takes place can be adjusted to maximise the chances of change taking place in a sustainable manner. The literature on quality also highlights the critical focus on creating opportunities for children and young people to develop the stable loving relationships that they need to thrive (see Duncan, 2020). However, the implementation literature also teaches us that this is not the work of a single individual practitioner, manager, or organisation. While some change may be within the locus of control of some individuals, systemic change and improvements in quality will only be achieved through all actors working in concert to deliver the change that children and young people in residential settings deserve.

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## **Acknowledgement**

The authors would like to thank our CELCIS colleague, Mihaela Manole, for the expert comments she provided on an earlier draft of this article.