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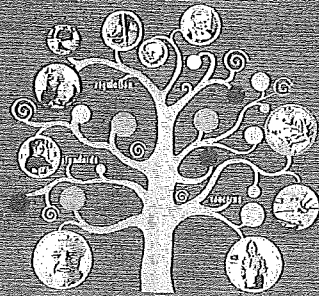
THE Care Inspectorate produces a range of publications and DVDs that are available free of charge to explain the role of the organisation and its work to improve the quality of care throughout Scotland.

These publications provide useful information for

people who currently use, or are preparing to use, care services as well as for their families and carers.

The publications include information about the National Care Standards, the level of care people should expect to receive and what to do if they need to make a complaint.

## Looking after your care



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# DON'T TRIP UP ON PLANNING TRIPS

Outings involving children need to be fully assessed before taking place

### COMPLAINT CASE STUDY

SUMMER is on its way! At this time of year, many nurseries start to think about outings for children. Such trips are often wonderful experiences for them, but careful planning is needed to ensure it turns out to be a safe, fun event.

This case study looks at a nursery visit to a museum where a child went missing and which resulted in a complaint about adequate supervision by the nursery. Fortunately, the child was unharmed, but the complaint investigation highlighted some very important lessons which all providers should heed when they plan outings.

Care Inspectorate investigators checked the planning for the visit and found that the adult:child ratio was one adult to between two and three children, and that all children were wearing high-visibility jackets. The nursery managers had also visited the museum with their own families prior to the outing to inform the planning for the visit.

However, subsequent feedback from staff suggested the museum was not sufficiently engaging for the children and there was not enough to occupy them for the time they were there. There was no enclosed area where they could gather at lunchtime and no outdoor or soft play facilities for the children to have a break.

The child went missing towards the end of the visit when a member of staff took five children with her to the gift shop. When she came out of the shop, all the groups and the parent helpers who were allocated to this member of staff had left the building and were getting on to the bus, which was parked a few yards from the main entrance.

When the staff member realised one of the children was missing, she thought it best to get the four children who were with her on to the bus before going to look



for the missing child. She told the security guard at the main entrance that a child was missing and went to the reception to broadcast a message. Soon afterwards, the missing child appeared with a security guard.

The investigators concluded that, while the service had planned and implemented an adequate adult:child ratio, the supervision was compromised by the fact that the parent helpers did not stay with the groups as they sometimes went off with their own children, leaving staff members at times with a one adult to five children ratio.

The investigators also concluded that not enough information had been gathered about the venue, and there was no plan of what to do if the children were not fully engaged with the museum or where they would eat their lunch. There were no instructions recorded about the shop. These issues had created difficulties for staff in supervising the children and should have been considered and documented at the planning stage.

Happily, the outing ended without any harm being caused. However, the potential risk was present and with more careful planning could have been foreseen and avoided. **CN**



## Lessons learned

1. Nursery managers must make sure that staff and parent helpers are clear about the importance of staying together in their allocated groups to maintain the adult:child ratio and ensure the safety of children on all outings.

2. Information gathered during visits to proposed venues for outings is evaluated, considered and included in any planning documentation prior to the outing taking place to ensure that all staff and parent helpers know what to expect.