



**Social Services
Inspectorate**

**GLEANN ALAINN SPECIAL CARE UNIT
IN THE
HEALTH SERVICE EXECUTIVE
SOUTH**

INSPECTION REPORT ID NUMBER: 349

**Fieldwork Dates: 5th and 6th October 2009
Publication Date: 18th January 2010
SSI Inspection Period: 11
Centre ID Number: 99**

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1. Introduction

The Health Information and Quality Authority (HIQA) Social Services Inspectorate (SSI) carried out an announced inspection of Gleann Alainn Special Care Unit (SCU) in the Health Services Executive South (HSES), under Section 69 (2) of the Child Care Act 1991. Sharron Austin (lead inspector) and Kieran O'Connor (co-inspector) conducted the inspection on the 5th and 6th October 2009. SCUs are inspected annually against the *National Standards for Special Care 2001* and the *Child Care (Special Care) Regulations 2004*. The last inspection took place in August 2008 (Report No. 247) with a follow-up inspection in March 2009 (Report No. 303).

Gleann Alainn is managed by the North Lee local health area of the HSE and is a national resource since January 2007. It offers secure residential care for up to five girls aged between 11 and 17 years inclusively. At the time of inspection there were three girls detained in the unit. Children are detained in a special care unit under a High Court Order on the basis that they pose a serious risk to themselves or others.

The unit is located in the grounds of a hospital. It is a single storey building surrounded by a large wooded area and green fields. A large perimeter fence had been erected recently which provided the girls with a large secure open area to the rear of the building.

Inspectors found that standards were well met in the unit. Inspectors found that children were well cared for and the external professionals interviewed spoke positively of the ethos within the unit which reduced the anxiety levels of the children while being detained. While there are some recommendations for improvements, the majority of the standards were well met and there were no areas where practice did not meet the required standard.

1.1 Methodology

Inspectors' judgements are based on an analysis of findings verified from several sources gathered through direct observation, examination of relevant records, an inspection of accommodation and interviews with three children, the acting unit manager, the acting deputy manager, two social care leaders, one social care worker, the HSE monitoring officer, the principal psychologist, the designated staff health and safety representative, the child care manager with line management responsibility for the unit, the co-ordinator of residential services HSES and the general manager. A telephone interview was carried out with a guardian-ad-litem. Questionnaires were completed by one social worker, one parent and the principal psychologist.

Inspectors also had access to the following documents:

- The unit's statement of purpose and function, policies and procedures
- The unit's register
- The children's care plans and care files
- Information on staff
- Information on children
- Administrative records
- Staff rosters
- Staff supervision and training records
- Fire safety compliance documents
- Evidence of insurance
- Details of unauthorised absences for previous twelve months (6)
- Details of physical interventions for the previous twelve months (23)

- Details of complaints made by children for the previous twelve months (1)
- Details of child protection notifications (1)
- Details of single separation for the previous twelve months (10)
- Monitoring reports (9)

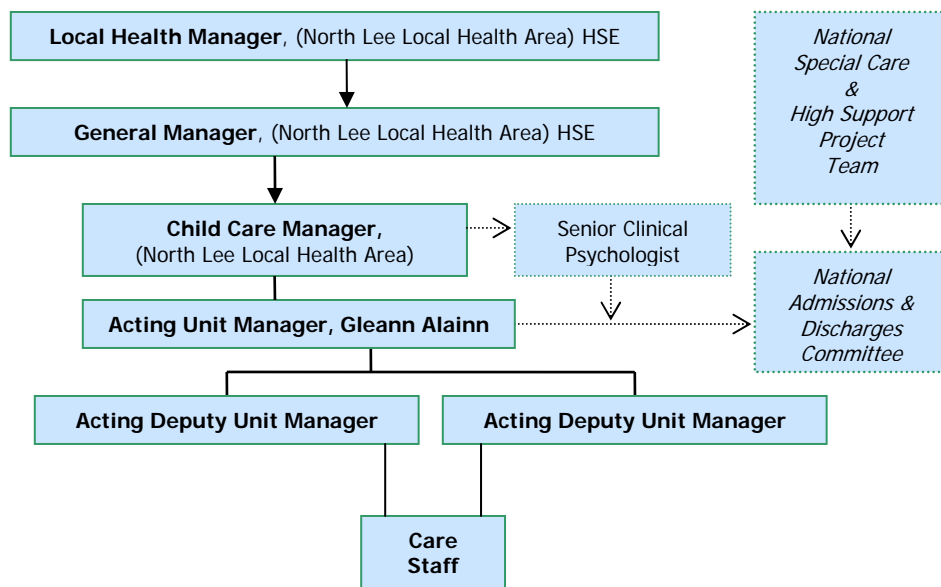
1.2 Acknowledgements

Inspectors wish to acknowledge the children, staff members and all other professionals who assisted in this inspection.

1.3 Management Structure

The unit was managed by an acting unit manager and two acting deputy unit managers. The acting unit manager reported to the child care manager of the North Lee local health area in the HSES, who in turn reported to the general manager. The national project team for special care and high support had an oversight of all SCUs nationally, and chaired a central admissions and discharges committee. The management structure is shown in the chart below.

Management Structure of Gleann Alainn SCU – October 2009



1.4 Data on children

Inspectors examined the unit's register and found that in the twelve months since the last inspection there had been six admissions and three discharges at Gleann Alainn. Details of the children present in the unit at the time of the inspection are given below.

Current children

Child	M/F	Age	Placing HSE Area	Length of Placement	Number of previous placements
# 1	F	14 (MD)	Dublin West	7 weeks	Foster care (2) Residential (2)
# 2	F	15 (SD)	Dublin West	6 weeks	Special care (1) Residential (1) Crisis Intervention Service (2)
# 3	F	16 (AB)	Dublin East	1 week 2 days	Special care (2) Detention (1) Residential (1)

Listed in order of length of placement

2. Summary of findings

Practices that met the required standard

Notification of significant events

This standard was met. The unit had a clear system for the notification of significant events and records of these notifications were maintained. Professionals interviewed were satisfied that notifications were made in a prompt manner, in accordance with unit policy and standard.

Monitoring

This standard was well met. The HSE monitoring officer visited on a monthly basis and had written nine reports since the August 2008 inspection on his findings. Copies of these were submitted to the SSI. He was satisfied with the level of communication in terms of being notified of significant events.

Consultation with children and complaints

The standards on consulting with children and complaints were good. The children were familiar with the complaints procedure and identified staff or external people they could talk to. One complaint by a young person had been made in the previous twelve months in relation to bullying. Inspectors examined the records in relation to this and found a detailed account of the investigation into the complaint which was brought to a satisfactory conclusion within a short timeframe.

Family contact

There was evidence from interviews and unit records that there was regular contact with families and carers where appropriate. Given the geographical location of the unit from the children's placing areas, Gleann Alainn had the facility to provide overnight accommodation to parents and families in an annex attached to the building which had its own entrance.

Emotional and specialist support

The standard on emotional and specialist support was good. The unit had the services of a dedicated principal clinical psychologist. The broad objectives of this service in relation to each referred child was *"to support and enhance the effectiveness of Gleann Alainn's therapeutic care of her, and to try to add to the current clinical understanding of her case"*. He attended staff meetings and supported key workers. He undertook direct work with some of the children. Those interviewed spoke highly of his involvement and the ease of accessibility to him for clarity in relation to individualised work with the children. Access to external services was maintained and facilitated where possible. The principal psychologist outlined the model of care to the inspectors during interview and hoped that the model could be agreed and signed off in due course. Inspectors have made a recommendation regarding this in the section on *purpose and function* below.

Primary Care/ aspects of daily living

Inspectors found that the children were well cared for and respected in the centre, and that individual identity was respected. The primary focus of care practice was the needs of the individual children. The children spoke positively about the staff and told inspectors that they felt cared for and safe. The centre had an experienced and competent staff team who established good relationships with children, their families and the other professionals involved with them.

Leisure activities

The children had opportunities to develop and maintain interests and participated in various leisure activities.

Referral and placement of children

All referrals to special care units come through the High Court after an application to the national admissions and discharge committee for special care. The acting unit manager sits on this committee.

Single separation

There were 10 incidents of single separation involving four children since the last inspection in August 2008. The duration of these was from five to 30 minutes and all were recorded appropriately and notified promptly.

Unauthorised absences

There had been six unauthorised absences involving six children since the last inspection. All absences were reported to the appropriate people including Gardai, parents, social workers, guardians-ad-litem, and the HSE monitoring officer. The length of time absent from the unit ranged from one minute to one to four hours. The longest of these absences was for 26 days. In this instance the child's whereabouts were known to the staff and Gardai; however, due to alleged lack of co-operation on behalf of the child's family members to ensure her safe return, this was a considerable period of absence from the unit.

Use of physical restraint

In the previous twelve months there had been 23 incidents of physical restraint/intervention involving five children. Each of these was of a short duration ranging from one to ten minutes. Two were of twenty to thirty minutes. As indicated above, the unit staff were trained in TCI and had also developed an effective strategy for responding to the personal alarm system installed in the unit and carried by all staff. The significant incident review group (SIRG) assessed each incident in which physical restraint was used and were satisfied that appropriate action had been taken. Inspectors were given details of these incidents and were satisfied that appropriate intervention was carried out.

Promoting positive behaviour

The quality of risk assessments was good and affirming of the children. This accounted for the low number of restraints, single separations and unauthorised absences. On review of the sanctions register, inspectors found that they were fair and proportionate.

Legal and Court work

Each young person had a copy of the High Court order on file. The children had court appointed guardians-ad-litem. They had frequent contact with the children and attended review meetings. A guardian-ad-litem interviewed by the inspector spoke very positively about the care provided in Gleann Alainn and said that the focus in the unit was on establishing a relationship with the young person and not on their length of stay in the unit thus reducing their anxiety levels.

Security

Concerns in relation to security were raised in a report provided to the High court in May 2008 following a particular incident. The management advisory group (MAG) reviewed security within the unit and ensured protocols and procedures were amended to safeguard against future security breaches. A perimeter fence had been erected recently which provided the girls with a large secure open area to the rear of the building. The majority of the unauthorised absences occurred prior to the erection of the perimeter fence. A HIQA SSI report to the High Court in March 2009 found that several measures had been taken to improve the security of the unit, such as: installation of a new system of locks and a CCTV system, the introduction of procedures for signing for and storage of keys. During this inspection, inspectors were satisfied that the standard in relation to security was met.

Safety and Fire Precautions

The unit had an up to date health and safety statement and an audit had been carried out by the HSE fire officer in February 2009. Fire safety training for 16 staff had taken place in February and August 2009. First Aid training was carried out with nine staff in April 2009. Fire drills had taken place on four occasions since February 2009.

Medicines were stored in a secure cabinet in an inner locked room off the staff room. The medication administration book was signed by two people each time medication was given to a child. Appropriate measures were in place which allowed the safe use of rooms containing potentially dangerous materials and implements.

Practices that partly met the required standard

Purpose and function

The unit had a written statement of purpose and function which had not been reviewed for some time. It did not reflect the current status of the unit or the population it catered for and it did not define its role within the national child care service. The day to day practice observed and evidenced through interviews was reflected in the statement. The acting unit manager told inspectors that a model of care was currently being developed which would be incorporated into the unit's statement of purpose and function. The principal psychologist and child care manager outlined the model of care to the inspectors during interview. The policies and procedures document furnished to the inspectorate was dated 1999.

Inspectors recommend that:

- The statement of purpose and function is reviewed to reflect the current status of the unit and define its role within the national child care service,
- the draft model of care is agreed and approved by HSE senior management as soon a matter of priority and incorporated into the statement of purpose and function and the unit's policies,
- the management advisory group (MAG) review and update the unit's policies and procedures.

Register

The unit maintained a register on the children which contained the majority of required information; however, there were some details missing. The monitoring officer stamped the register each time he checked it. This obscured some information on the register. While this practice is good, inspectors advised that the monitoring officer would evidence his check in a more appropriate place within the register. Inspectors also advised the unit to record on the unit register where care files are archived after a young person is discharged. Inspectors recommend that missing details within the centre register are rectified immediately.

Management

The standard on management was partly met. The managers of the unit were not qualified in social care. Each had other third level qualifications and had been in their respective positions for several years. There were clear external management structures in place. The unit manager and child care manager told inspectors that they met for supervision on a monthly basis. A management advisory group (MAG) had been established in September 2008 which prioritised four primary areas of concern. These were governance, staff structure, safeguarding and supervision. Its membership included the child care manager with line management responsibility, the principal psychologist, the co-ordinator of children's residential services and the project manager from the national office for special care and high support. It has met on a regular basis. Issues such as safety, accountability, leadership and support were identified by the MAG as being insufficiently robust. A decision was made in November 2008 to revise the management structure so as to provide a framework which would address the concerns as indicated above. The MAG proposed that a post of shift co-ordinator be re-introduced to Gleann Alainn so as to "*ensure a safe and resilient care environment*". This was still outstanding during this inspection.

Inspectors recommend that:

- the MAG enact their decision of November 2008,
- the management structure within the unit is clearly defined so that roles and responsibilities are understood by all and is suitable for the purpose and function of the unit,
- a stronger emphasis is placed on accountability and reporting relationships by all staff,
- the post of shift co-ordinator is established without further delay,

Staffing

At the time of inspection, the unit had a total of 32.25 approved whole time equivalent posts filled by:

- An acting unit manager,
- two deputy unit managers,
- 28.25 social care staff
- one administrator

Five staff were unqualified and the managers of the unit were not qualified in social care. A recommendation determining whether the qualifications of the managers were appropriate for their roles was made in the previous inspection report ID. No.247. It was still not met in the follow up inspection in March 2009. This recommendation still stands. Opportunities to attain qualifications over a three year period had been given to staff following a time limited collaboration between the HSES and the Institute of Technology in Tralee. Three staff members had attained the relevant qualification through this arrangement.

Standard 2.15 requires that the number of staff on duty at any time is sufficient to promote the children's welfare and to maintain their safety and security. At the time of the inspection, the unit, which had a potential operating capacity for five placements, was not operating to full capacity. Full capacity had not been achieved in the previous twelve months prior to the inspection for several reasons outlined to the inspectors. The number of young people cared for in the unit at any one time was four. Inspectors were told by the acting unit manager that they were open to referrals and that one was pending admission to the unit.

The unit had recently recruited four agency staff. This practice was new to this local health area and should be only used as a short term arrangement. On inspection of the personnel files of recently recruited staff, inspectors found that appropriate vetting procedures had been followed; however, there were discrepancies around some information that had yet to be corrected.

Inspectors examined the staff roster which ran over a three week cycle. Five staff worked from 8.00a.m. to 2.00p.m. (two of these were sleep over staff from the previous night). Five staff worked from 1.00p.m. to 11.00p.m. and two of these staff stayed on for a sleep over shift. Two additional staff worked from 9.00p.m. to 9.00a.m. as waking night staff. There had been occasions in the previous twelve months that there was not sufficient cover on shift. The acting unit manager told inspectors that the unit was short eight staff due to sick leave, maternity leave and administrative leave. This resulted in the managers themselves covering the roster at some of the most vulnerable times.

The staff roster did not facilitate team meetings. On inspection of team meeting minutes inspectors found that attendance was poor, minutes were unsigned and there was no evidence that staff not present at meetings read the minutes.

Inspectors recommend that:

- the HSES should determine whether the qualifications of the unit managers are suitable for its purpose and function and make provision for managers to gain qualifications if not,
- any discrepancies regarding information held on personnel files are corrected immediately.
- the roster and deployment of staff are reviewed so as to facilitate full staff meetings and ensure there is sufficient staff on duty to ensure the provision of safe care at all times regardless of capacity.

Administrative and Care Files

Overall, the recording systems that operated in the unit were of a good quality. On examination of care files inspectors found that some of the statutorily required documents were not present. The files of children who had been discharged from the unit were archived in a central storage facility used by the HSES. During the accommodation check of the building inspectors found four boxes of care files in a staff bedroom that had yet to be archived. The unit did not have a policy on records kept on computer.

Inspectors recommend that:

- all deficits in statutorily required documents are rectified immediately,
- the files of children who have been discharged from the unit are archived within an appropriate timeframe,
- the unit develops a policy on computer generated information and ensures that staff are compliant with this.

Supervision

The previous inspection had highlighted serious deficiencies regarding formal supervision of staff and managers and had made a recommendation that regular formal supervision should be in place. The HSES in response to this recommendation engaged the services of an independent expert to carry out a review of policy and practice. She produced a report in December 2008 which stated that the "*practice of professional supervision over recent years has been ad-hoc and problem-based in the main with no supporting evidence that staff have developed their understanding of supervision*". The report went on to recommend steps that were required without further delay. In the ten months since the report was issued there had been minimal progress on meeting these recommendations. This delay is unacceptable. On inspection of supervision files it was evident that there was little or no progress in this area until June 2009 when the frequency and quality of supervision changed significantly. Inspectors were told that supervision could not be implemented fully until the introduction of the shift co-ordinator post mentioned earlier in the report. Once established, a shared training input for all supervisors is to be carried out. Inspectors recommend that the implementation of the findings of the report from the independent expert regarding formal supervision is carried out without further delay.

Training and Development

This standard was partly met. The majority of staff were trained in core areas such as therapeutic crisis intervention (TCI), fire safety and first aid. Training in *Children First: National Guidelines for the Protection and Welfare of Children* had taken place for most staff some years before this inspection. More recently appointed staff still required this training. It was evident during

interviews with these staff that induction training was of a poor standard. Given the vulnerable population of the unit this was an unsafe practice.

Inspectors recommend that:

- staff who require training in *Children First: National Guidelines for the Protection and Welfare of Children* are provided with opportunities to do so,
- there is appropriate induction training for all new staff.

Individual care in group living

Through observation during the inspection and interviews with external professionals it was evident that staff related to the children in ways that took account of their individuality and specific issues in relation to their restricted liberties. Children could make and receive telephone calls in private. Since the 2008 inspection mealtimes had become more formal and inspectors joined the children and staff for their evening meal. This was a positive and enjoyable experience. Dietary preferences were considered and opportunities for the children to partake in the preparation and cooking of meals were afforded. Each young person had a key worker. Key worker sessions were generally of an informal nature; however, the arrangement for recording key worker sessions did not adequately reflect the amount of work carried out with the children.

While the unit facilitated the children in the practice of their religion where practicable and considered individual ethnic and cultural identities, it did not have a comprehensive policy and programme of training on diversity and anti-discrimination as required by Standard 6.9.

Inspectors recommend that:

- key worker records are reviewed to ensure that they fully reflect the work carried out with the children,
- the unit develops a comprehensive policy and programme of training on diversity and anti-discrimination as required by Standard 6.9.

Safeguarding and Child Protection

The HSE had developed key policies in relation to safeguarding and child protection within the previous twelve months comprising of: (i) safeguarding policy (ii) child protection policy, (iii) complaints policy and (iv) guidelines relating to professional relationships between staff and children. On examination of unit records and during interviews with staff and children it was evident that practice in relation to child protection was good. Safeguarding was less well understood. Inspectors recommend that guidance and training on these policies is provided as a priority.

There was one child protection concern notified in the previous twelve months. An allegation against a staff member had resulted in this person being on administrative leave since September 2008. An investigation was ongoing and the young person had since been discharged from the unit in October 2008. Inspectors were concerned that this was a considerable length of time for the matter to be investigated and enquired as to what measures were taken to support the people concerned. During interview with the child care manager, inspectors were told of the measures taken to date and that the matter should be concluded by November 2009. The child care manager should formally notify the inspectorate of the outcome of the investigation when the matter is concluded.

Care plans and reviews

The standard on care planning and statutory reviews was partly met. Care plans viewed by inspectors were of varying quality and as noted in the previous inspection were geared to meet the

requirements of the national admissions and discharge committee to secure a placement in special care. They did not give detail of longer-term plans. Some of the care plans were relevant to previous placements. Inspectors were told that exit plans identified in the care plan did not always materialise, which on occasion resulted in placements being extended until appropriate alternative placements were sourced. Reviews took place on a monthly basis; however, this could only be evidenced by minutes recorded on some care files and there was no evidence of reviews on other files. The children told inspectors that they attended their reviews and had opportunities to express their opinions regarding their care placements.

Inspectors recommend that:

- supervising social workers ensure that care plans distinguish between the overall long term plan and the SCU's placement plan,
- minutes of decisions made at statutory reviews are maintained on care files and are used to update the care plan accordingly.

Social work role

Each young person had an allocated social worker. They visited the children in accordance with the statutory requirements. As the unit was a national resource, children were placed from various geographical regions in the country. In the twelve months prior to this inspection children had been placed in the unit from Dublin and Galway. Inspectors found that outside of monthly reviews held in the unit, the frequency of visits and availability of some social workers was limited and the time allowed for private visits with the children after their reviews was restricted due to travel constraints. Social workers spoke positively about the care provided in Gleann Alainn and were satisfied with the level of communication and notification. There was evidence that one social worker had read the unit log books and files.

Inspectors recommend that:

- supervising social workers read unit logs and files from time to time.
- social workers who have to travel a considerable distance ensure that they allow sufficient time for a private visit with the young person when attending a review meeting.

Access to information

The standard on access to information was partly met. Children were aware of their right to access information, and that access in practice was mostly limited to daily log books. Inspectors recommend that the right to access information is more proactively promoted and facilitated, and that staff are enabled to be confident in putting it into practice.

Health

The children had access to a G.P and specialist services external to the unit. Inspectors were concerned that the unit had no comprehensive medical histories for some of the children. Inspectors could not find evidence a medical on admission for one young person. In the absence of any relevant documentation, inspectors could also not find evidence of efforts made to obtain the information. Inspectors recommend that the medical/health files are reviewed and that the steps taken to obtain medical information are recorded on file.

Education

The standard on education was partly met. There was a school room in the unit resourced by teaching staff under the direction of an education co-ordinator. In the last inspection report a recommendation was made to the HSE nationally to ensure that the continuity of education for

children admitted and discharged from the SCU's is sustained. This was still unmet during the follow up inspection in March 2009. This recommendation still stands.

Premises

The premises had been the subject of several recommendations in previous inspection reports. Considerable resources had been put in to Gleann Alainn since the last inspection to make the current premises fit for purpose. It was evident during this inspection that a considerable amount of work had been carried out to address serious accommodation issues. Inspectors were told that arising out of safety concerns, alternative locks for the bathrooms had yet to be sourced that could not be compromised by the children. The acting unit manager told inspectors that there had been some initial teething problems and minor maintenance issues mentioned above.

It was not clear how the annex to the building was to be used. During the inspection it served several purposes such as a classroom and meeting room. Given this addition to the wider facilities within the unit it is important that it is not left under utilised and its purpose should be clearly identified. The unit had all the relevant documentation required by the regulations including insurance and written confirmation of fire safety and building control compliance.

Inspectors recommend that:

- the sourcing of alternative locks for the bathrooms is a priority,
- a programme is developed to ensure standards of structural and decorative order are maintained.

Practices that did not meet the required standard

There were no areas where inspectors found that practice did not meet the required standard in any respect. This was a significant finding and inspectors commend the unit management and staff for this.

3. Findings

3.1 Purpose and function

Standard
The unit has a written statement of purpose and function that accurately describes what the unit sets out to do for children and the manner in which care is provided. The statement is available, accessible and understood. The unit's role in relation to the wider child care services (including regional and national) is clearly set out by the Health Services Executive

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Purpose and Function		√	

Recommendation:

1. The HSES should ensure that:

- the statement of purpose and function is reviewed to reflect the current status of the unit and define its role within the national child care service,
- the draft model of care is agreed and approved by HSE senior management as a matter of priority and incorporate it into the statement of purpose and function and the unit's policies,
- the management advisory group (MAG) review and update the unit's policies and procedures.

3.2 Management and staffing

Standard There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and meet the needs of the children. The unit is effectively managed and staff are organised and deployed so as to operate the unit effectively and efficiently to the required standard.			
	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Management		√	
Register		√	
Notification of significant events	√		
Staffing		√	
Supervision and support		√	
Training and development		√	
Administrative files		√	
Vetting		√	

Recommendations:

2. The HSES should ensure that:
 - the management advisory group (MAG) enact their decision of November 2008,
 - the management structure within the unit is clearly defined so that roles and responsibilities are understood by all and is suitable for the purpose and function of the unit,
 - a stronger emphasis is placed on accountability and reporting relationships by all staff,
 - the post of shift co-ordinator is established without further delay,
 - the MAG review and update the unit's policies and procedures.
3. The HSES should ensure that missing details within the centre register are rectified immediately.
4. The HSES should ensure that:

- they determine whether the qualifications of the unit managers are suitable for its purpose and function and make provision for managers to gain qualifications if not,
 - any discrepancies regarding information held on personnel files is corrected immediately.
 - the roster and deployment of staff are reviewed so as to facilitate full staff meetings and ensure there is sufficient staff on duty to ensure the provision of safe care at all times regardless of capacity.
5. The HSES should ensure that the implementation of the findings of the report from the independent expert regarding formal supervision are carried out without further delay.
6. The HSES should ensure that:
- staff who require training in *Children First: National Guidelines for the Protection and Welfare of Children* are provided with opportunities to do so.,
 - there is appropriate induction training for all new staff.
7. The HSES should ensure that:
- all deficits in statutorily required documents is rectified immediately,
 - the files of children who have been discharged from the unit are archived within an appropriate timeframe,
 - the unit develops a policy on computer generated information and ensures that staff are compliant with this.

3.3 Monitoring

Standard			
The Health Services Executive has adequate arrangements in place to enable an authorised person, on behalf of the Health Services Executive to monitor statutory and non-statutory children’s residential centres.			
	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Monitoring	√		

3.4 Planning for children

Standard

There is a written care plan to promote the welfare of each young person which is subject to regular review. This stresses and practically supports contact with families, preparation for adulthood, promotes education and health needs and addresses the emotional and psychological needs of the children.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Referral and placement of children	√		
Statutory care planning and review		√	
Legal and Court work	√		
Contact with families	√		
Supervision/visiting of children		√	
Social Work role		√	
Emotional and specialist support	√		
Children's care files		√	

Recommendations:

8. The HSES should ensure that:
 - supervising social workers ensure that care plans distinguish between the overall long term plan and the SCU's placement plan,
 - minutes of decisions made at statutory reviews are maintained on care files and are used to update the care plan accordingly.
9. See recommendation No.7
10. The HSE should ensure that:
 - supervising social workers read unit logs and files from time to time.
 - social workers who have to travel a considerable distance ensure that they allow sufficient time for a private visit with the young person when attending a review meeting.

3.5 Care of children

Standard

Children are cared for by staff who can relate effectively to them. Day- to-day care is of good quality and provided in a way which takes account of their individual needs in relation to age, race, culture, religion, gender and disability. Children are cared for in a manner which safeguards and actively promotes their legal and civil rights. Children whose conduct is unacceptable are dealt with in accordance with positive disciplinary measures approved by the Health Services Executive.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Protection		√	
Staff relationships	√		
Race, culture, religion, gender and disability	√		
Health		√	
Access to Information		√	
Consultation	√		
Privacy, dignity and Individuality	√		
Meals	√		
Personal appearance	√		
Leisure Activities	√		
Promoting positive behaviour	√		
Restraint and single separation	√		
Complaints	√		
Absence without authority	√		

Recommendations:

- 11. The HSES should ensure that guidance and training on safeguarding and child protection policies is provided as a priority.**
- 12. The HSES should ensure that they formally notify the inspectorate of the outcome of the investigation into the child protection notification.**
- 13. The HSES should ensure that the medical/health files are reviewed and that the steps taken to obtain medical information are recorded on file.**
- 14. The HSES should ensure that the right to access information is more proactively promoted and facilitated, and that staff are enabled to be confident in putting it into practice.**
- 15. The HSES should ensure that:**
 - key worker records are reviewed to ensure that they fully reflect the work carried out with the children,**
 - the unit develops a comprehensive policy and programme of training on diversity and anti-discrimination as required by Standard 6.9.**

3.6 Premises, safety and security

Standard

The premises and associated outdoor areas are designed to prevent unauthorised entry or exit. They should facilitate supervision and minimise opportunities for self harm while providing accommodation which is, in so far as practicable, appropriate to its designation as a children's home. It must also be properly maintained and furnished.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Risk Assessment	√		
Location and design	√		
Accommodation general	√		
Accommodation individual children	√		
Maintenance and repairs		√	
Safety and fire precautions	√		
Security	√		

Recommendations:

16. The HSES should ensure that:

- the sourcing of alternative locks for the bathrooms is seen as a priority,
- a programme of maintenance and capital works is developed to ensure standards of structural and decorative order are maintained.

3.7 Education

Standard

Education should be seen as an integral part of the care of the young person. The education of all children should be actively promoted by all involved. In so far as it is practicable, units should aim to provide for those of school age, a broad and balanced curriculum appropriate to their age, ability and level of attainment with a view to continuing in open conditions or a return to mainstream school. Where appropriate, children over the age of sixteen should be offered a programme where vocational preparation, training and work experience or transition to further education.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Education		√	

Recommendation:

17. The HSE nationally should ensure that the continuity of education for children admitted and discharged from the SCU is sustained.

4. Summary of Recommendations

1. The HSES should ensure that:
 - the statement of purpose and function is reviewed to reflect the current status of the unit and define its role within the national child care service,
 - the draft model of care is agreed and approved by HSE senior management as a matter of priority and incorporated into the statement of purpose and function and the unit's policies,
 - the management advisory group (MAG) review and update the unit's policies and procedures.
2. The HSES should ensure that:
 - the management advisory group (MAG) enact their decision of November 2008,
 - the management structure within the unit is clearly defined so that roles and responsibilities are understood by all and is suitable for the purpose and function of the unit,
 - a stronger emphasis is placed on accountability and reporting relationships by all staff,
 - the post of shift co-ordinator is established without further delay,
 - the MAG review and update the unit's policies and procedures.
3. The HSES should ensure that missing details within the centre register are rectified immediately.
4. The HSES should ensure that:
 - they determine whether the qualifications of the unit managers are suitable for its purpose and function and make provision for managers to gain qualifications if not,
 - any discrepancies regarding information held on personnel files is corrected immediately.
 - the roster and deployment of staff are reviewed so as to facilitate full staff meetings and ensure there is sufficient staff on duty to ensure the provision of safe care at all times regardless of capacity.
5. The HSES should ensure that the implementation of the findings of the report from the independent expert regarding formal supervision is carried out without further delay.
6. The HSES should ensure that:
 - staff who require training in *Children First: National Guidelines for the Protection and Welfare of Children* are provided with opportunities to do so.,
 - there is appropriate induction training for all new staff.
7. The HSES should ensure that:
 - all deficits in statutorily required documents is rectified immediately,
 - the files of children who have been discharged from the unit are archived within an appropriate timeframe,
 - the unit develops a policy on computer generated information and ensures that staff are compliant with this.

8. The HSES should ensure that:
 - supervising social workers ensure that care plans distinguish between the overall long term plan and the SCU's placement plan,
 - minutes of decisions made at statutory reviews are maintained on care files and are used to update the care plan accordingly.
9. See recommendation No.7
10. The HSES should ensure that:
 - supervising social workers read unit logs and files from time to time.
 - social workers who have to travel a considerable distance ensure that they allow sufficient time for a private visit with the young person when attending a review meeting.
11. The HSES should ensure that guidance and training on safeguarding and child protection policies is provided as a priority.
12. The HSES should ensure that they formally notify the inspectorate of the outcome of the investigation into the child protection notification.
13. The HSES should ensure that the medical/health files are reviewed and that the steps taken to obtain medical information are recorded on file.
14. The HSES should ensure that the right to access information is more proactively promoted and facilitated, and that staff are enabled to be confident in putting it into practice.
15. The HSES should ensure that:
 - key worker records are reviewed to ensure that they fully reflect the work carried out with the children,
 - the unit develops a comprehensive policy and programme of training on diversity and anti-discrimination as required by Standard 6.9.
16. The HSES should ensure that:
 - the sourcing of alternative locks for the bathrooms is seen as a priority,
 - a programme of maintenance and capital works is developed to ensure standards of structural and decorative order are maintained.
17. The HSE nationally should ensure that the continuity of education for children admitted and discharged from the SCU is sustained.