GLEANN ALAINN SPECIAL CARE UNIT
SOUTHERN HEALTH BOARD

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1. Executive Summary

The Social Services Inspectorate (SSI) carried out the inspection of the Gleann Alainn Special Care Unit (SCU) in Cork under the *Child Care Act 1991, Section 69 (2)* which provides authority for the inspection of the social services functions of health boards, including children's residential units. The unit was managed by the Southern Health Board (SHB) and situated in the North Lee Community Care Area (NLCCA). The inspection took place over from 2nd – 4th September 2003. The lead inspector was Michael McNamara, and Ann Ryan and Kieran O'Connor were support inspectors.

Gleann Alainn provides short-term special care for up to seven girls subject to detention orders or wardship orders who are aged 11 to 17 years at the point of admission. It is managed by SHB as a regional resource for the Mid-Western Health Board (MWHB), and the South Eastern Health Board (SEHB) and the SHB. It is based in a health board property that was converted for its current use. This was the fourth annual inspection of Gleann Alainn carried out by the Social Services Inspectorate (SSI). Readers wanting a more detailed account of the inspection should refer to the main sections of the report.

This inspection was within a cycle of annual inspections for special care units, but it was also carried out in anticipation of the implementation of the Child Care Act 1991, Part IVA, Section 23K (2), as amended by the Children Act 2001, Section 16. Part 3 of the Children Act 2001 which provides a specific statutory scheme for regulating special care units.

At the date the inspection was announced there were six girls in the unit. Four were placed by the SHB under wardship orders from the circuit court, and the other two by the MWHB and SEHB under detention orders from the high court. Three were aged 15 and three 17 years. The lengths of placement varied form five weeks to nine months. However, two of the young people were re-admitted to the SCU after the breakdown of placements in the local girls' high support unit (HSU). Another young person had experienced several moves between the SCU and the HSU during a period of transition out of special care. For eight months prior to the inspection she was looked after in a wing of the unit by the staff from the HSU. She and the staff who looked after her were included in the inspection, and where appropriate, reference is made to this arrangement in the report.

The centre had a complex management structure. The manager of the unit reported to the child care manager for the NLCCA. There was a management committee, an admissions and discharges committee, and each young person had a case management team. Since the last inspection the SHB has appointed monitors as required by the regulations.

Inspectors found evidence of a strong commitment to providing a high quality service to the young people. They were cared for in a warm and professional manner, and were extremely positive about the care they received and about the relationships they had with the unit managers and staff. There was a clear ethos of respect for young people's rights. They were consulted about decisions that affected their lives, and although they were in a unit for the purpose of detention, every effort was made to make daily life experiences as normal as possible. In interviewing the young people inspectors found that they did not make reference to the aspects of security of the SCU. One young person, who had been in the unit for a long period of time told inspectors, "It's more the staff than the building. They have been there for me. They never hold grudges, no matter what I do. They will listen and take you at your word. I definitely trust them." Staff are to be highly commended for quality of care to which this statement gives testimony.

The Gleann Alainn staff team consisted of an acting unit manager, two deputies, and 25 staff, 15 of whom were in full time permanent posts; and there were 17 HSU staff working at the unit, including the deputy manager.

Twenty six of the 28 staff at Gleann Alainn had Garda clearances. Twenty two were received before the members of staff commenced employment. Ten of the Gleann Alainn staff had three references, 14 had two, two staff had one, and two had none. In the HSU, 15 out of 17 staff had Garda clearances, 12 of which were received before the staff took up their posts. Only one member of the HSU staff had three references, eleven had two, two had one, and three had none. The quality of some of the references was unsatisfactory. Inspectors were not satisfied that complete vetting procedures had been followed for all staff in both groups.

The quality of primary care in the unit was generally of a high standard. There was ample evidence of carefully considered day-to-day care tailored to the individual needs of the young people. The ethos of the service was based on the quality of the relationships between the staff and young people, and inspectors found that several of the unit's policies were reflected in practice. Privacy, dignity and individuality were respected and promoted. Young people were included in discussions about their future, in reviews, and in residents' meetings, and could make decisions about day-to-day living, such as choice of food and clothing. They were given good opportunities to engage in a wide range of activities in the local community, and staff were committed to promoting and facilitating their links with their families. The management of behaviour was good. Few sanctions were used, and there was a low incidence of unauthorised absences or the use of physical restraint and single separation.

Parents told inspectors that they were involved and kept informed about their children's lives. They were included in the case management teams. Provision for meeting the general medical needs of the young people was well within the requirements of the standards.

Inspectors had concerns about a number of areas where the standards were not met. Chief amongst these were:

- There was a need for statutory care plans to be produced. Inspectors found only three care plans in the files of six young people. The recommendation made in this report follows recommendations in respect of care plans in all three of the previous Gleann Alainn reports.

- There were problems for the young people in the unit needing to access a psychiatric service. These were subject of recommendations in the previous two reports. Inspectors found that there were significant difficulties for some young people accessing psychiatric services because of their age or their geographical origin.

- There were difficulties in providing education to the young people in the unit.

- The recording system needed to be more systematic and thorough. In particular, inspectors found several items required by the regulations not present on the young people's care files.

- The complaints system needed to have an independent element, as recommended in the inspection report of 2001.

- The recently developed anti-bullying policy needed to refer to the child protection processes as recommended by inspectors in 2001.

- The significant difficulties in moving young people on from Gleann Alainn need to be resolved.

Accommodation in the centre showed some signs of wear and tear. The standard of décor and furnishings was good, providing an ethos of respect for the young people, and efforts were made to create a domestic setting for them. However, there were several areas in which minor repairs and a higher standard of housekeeping were necessary.

Amongst other issues, inspectors made recommendations about revision of the statement of purpose and function in the light of the implementation of the Children Act 2001, training in TCI, Children First and safeguarding, training in first aid for a wider number of staff, the proposals of the monitors of the board in respect of the unit, the development of a policy on facilitating young people in the practice of their religion, access to information, an inter-board protocol for dealing with complaints and allegations of abuse, improvements in the maintenance of the unit, and the conduct of health and safety audits.

While the report outlines a number of recommendations to bring aspects of the service to a level that will meet the requirements of the *National Standards for Special Care Units*, the staff team are highly commended for the extent to which they provide a consistent quality of care for the young people in a manner that allows them to feel safe, supported, consulted, and respected, and assists them in moving towards the future with greater confidence and self awareness.

2 Introduction

The Social Services Inspectorate (SSI) carried out the inspection of the Gleann Alainn Special Care Unit (SCU) in Cork under the *Child Care Act 1991, Section 69 (2)* which provides authority for the inspection of the social services functions of health boards, including children's residential units.

The unit was managed by the Southern Health Board (SHB) and situated in the North Lee Community Care Area (NLCCA). A pre-inspection visit was made on the 19th August 2003 during which the inspection process was explained to staff, and the premises were seen for the first time. The inspection took place over three days from 2nd – 4th September 2003. The lead inspector was Michael McNamara, and Ann Ryan and Kieran O'Connor were support inspectors.

2.1 Methodology

The inspectors had access to the following documents during the inspection:

- A statement on the purpose and function of the centre,
- The centre's statements of policies and procedures,
- The young people's care files,
- The young people's daily log books,
- All administrative and recording systems,
- Questionnaires completed by social workers,
- Questionnaires completed by parents,
- Census forms on young people,
- Census forms on staff members,
- A sample of personnel files,
- Staff rotas,
- The centre's health and safety statement.

In the course of the inspection inspectors interviewed four young people living in the unit. They also interviewed the mothers of two of the young people, the general manager and child care manager, the acting unit manager and the unit's two acting deputy managers, eight residential staff, five social workers, a guardian-ad-litem, and the senior clinical psychologist associated with the unit. The lead inspector had discussions over the telephone with the mother of one of the young people and with the ex-principal of the school. Owing to special circumstances pertaining at the time of the inspection, inspectors also interviewed the deputy manager and two care staff from one of the board's HSUs, and had access to census information on the HSU staff group. Inspectors observed the daily routines and shared meals with staff and young people.

2.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young people, their parents, staff of the unit, health board managers and other professionals in this inspection. We also wish to thank the young people for their assistance and hospitality.

3. Setting the scene: background, the centre and its population

3.1 Background

Gleann Alainn is a special care unit (SCU) providing residential accommodation for up to seven girls subject to detention orders who are aged 11 to 17 years at the point of admission. It is managed by the NLCCA as a regional resource for the SHB, the Mid-Western Health Board (MWHB), and the South Eastern Health Board (SEHB). It is based in a building belonging to the health board that was converted for its current use. This was the fourth annual inspection of Gleann Alainn carried out by the Social Services Inspectorate (SSI).

For eight months prior to the inspection one of the young people at Gleann Alainn was looked after in a wing of the unit by the staff from the HSU. The young person was the subject of a detention order and was resident in the SCU at the time that the inspection was announced, so she and the staff who looked after her were included in the inspection. Where it is appropriate, reference is made to this arrangement in the report, and to the HSU's function as a step-down unit for Gleann Alainn.

3.2 Details of current and previous placements at date of inspection

YOUNG PERSON	AGE	CARE STATUS	REFERRING BOARD	LENGTH OF TIME IN SCU	PREVIOUS PLACEMENTS
# 1*	17	Wardship	SHB	9 months	High Support Unit
# 2	17	Detention Order	SEHB	11 weeks	High Support Unit
# 3*	17	Wardship	SHB	5 weeks	High Support Unit
# 4*	15	Wardship	SHB	5 months	High Support Unit
# 5	15	Wardship	SHB	4 months	Respite Foster Care
# 6	15	Detention Order	MWHB	5 weeks	Residential Placement

• *= Readmission from **HSU***

The three young people re-admitted to the SCU had originally been placed in the unit one year ten months, one year eight months, and nine months respectively prior to the 2003 inspection.

3.3 Management structure

Gleann Alainn had an acting unit manager who had been in post since June 2000. He reported to the child care manager of the North Lee Community Care Area (NLCCA), who in turn reported to the general manager. There were two acting deputy unit managers. Within the unit, the staff group was split into three teams each of which had a team co-ordinator who reported to the acting deputy managers.

At the time of the inspection, the acting unit manager was on the point of moving to a new post and his place was due to be filled temporarily by one of the acting deputy unit managers. The incumbent acting unit manager intended to move to his new post by a process of gradual transition which would be completed by the end of November 2003. No other changes in the management structure were planned.

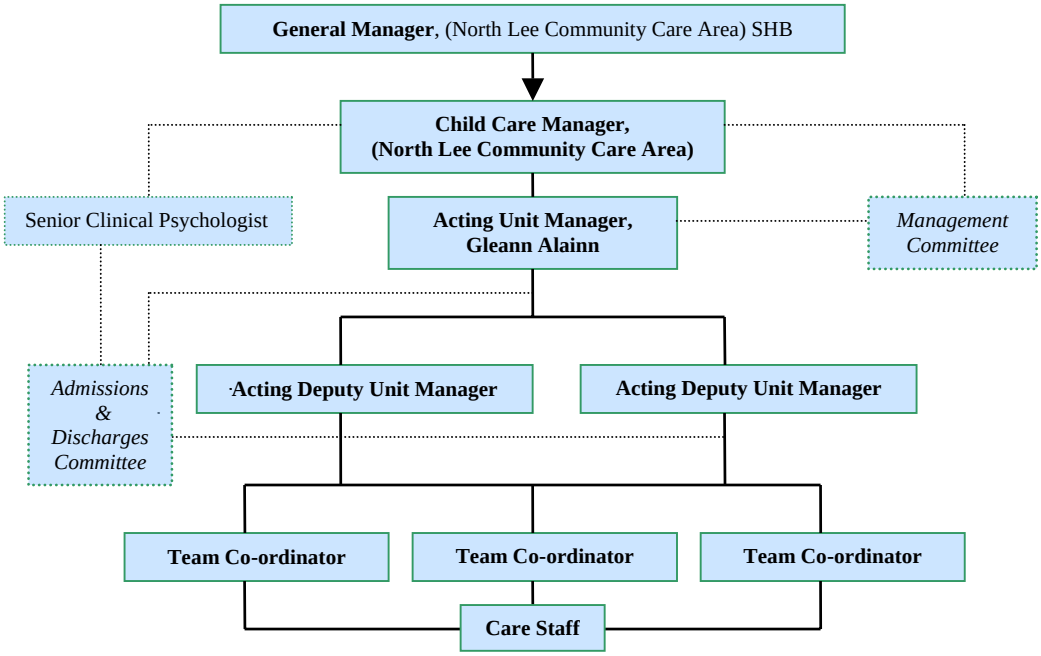
The unit had a management committee which met every three months. It was chaired by a business manager of the SHB, and its members included: the child care manager, the principal social worker for the NLCCA, the acting unit manager of Gleann Alainn, the acting unit manager of the board's high support unit for boys, and the principal of the educational facility. The committee served as an advisory board to the acting manager of the unit and approved the policies of the unit.

Some management responsibilities devolved to other groups. There was a case management team for each young person. The case management team generally consisted of the principal social worker or social work team leader, the social worker, the acting manager of Gleann Alainn, parents, the keyworker, a representative of the school, and other relevant professionals such as the guardian-ad-litem. The role of the case management team is discussed further in 4.3.4 below.

In certain cases there was also a core group made up of a smaller group of representatives of the case management team, and others that might be co-opted into it, such as a representative of the Gardai. The core groups were task specific and short term, and met at a frequency determined when they were established.

As shown in the chart below outlining the structure of the management of the SCU at the time of the inspection, there was an admissions and discharges committee. Its function is described in detail in 4.3.1 below.

Management Structure of Gleann Alainn Special Care Unit – September 2003



4. Standards: the findings

4.1 Purpose and Function

4.1.1 Role of unit

The unit's role in relation to the wider child care services (including regional and national) is clear and set out by the Health Board or Area Health Authority.

In its statement of purpose and function the unit was clearly described as a regional SCU offering short-term care for up to seven girls who are subject to detention orders and aged up to 17 years at the point of admission. The SCU covered the areas served by the MWHB, SEHB, and SHB.

4.1.2 Statement of purpose and function

The unit has a written statement of purpose and function that accurately describes what the unit sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

The statement of purpose and function said that Gleann Alainn SCU provided a short-term programme of care, usually for three to six months, in a controlled and safe environment, as part of the continuum of residential care in the Southern region. It stated that the unit was for adolescent girls with a history of impaired socialisation and impaired impulse control for whom other forms of intervention have been tried, who had absconded from open settings, were at risk of harming themselves or others, and who could not be looked after in a less secure environment. For the most part, practice in the SCU was accurately reflected in the statement. However, there had been difficulties moving young people on from the unit, and as a consequence their placements in the SCU were extended to medium term periods. This is referred to in greater detail in 4.3.1 below.

Girls were placed at the unit under orders from the court authorising the restriction of their liberty. The restriction of liberty was defined in detail in the statement, and an appendix to the statement outlined the stages in relation to a course of excursions out of the unit.

With the implementation of the Children Act 2001 admission to the SCU will be by application to the district court for special care orders only, and the use of wardship orders for this purpose will cease. The statement of purpose and function will need to be revised to reflect the change in the legal requirements for admission. The revision of the statement should give appropriate recognition of the role of the family in the lives of young people for whom special care orders are being considered. To some extent the involvement of parents in the case management teams should ensure that they are included in a partnership with the board. This is important not only for the maintenance of links between the young person and her family, but also because in many instances young people return to their families after they leave care.

The statement referred to the needs of girls in the unit as those of all young people in care, and listed several needs, including: a sense of security, control, clear boundaries, praise and recognition, self-esteem, and a sense of personal identity. A version of the statement was

prepared for young people and their parents. It was in a question and answer format, and was written in clear, accessible language.
It advised young people that if they wished to make a complaint they could either talk to a member of staff they felt comfortable with or to an appropriate adult outside the unit, such as their solicitor or social worker.

Recommendation

1. **On the implementation of the Children Act 2001 and the introduction of special care orders, the board should revise the statement of purpose and function to reflect the new legal requirements that will be in place.**

4.2 Management and staffing

4.2.1 Staffing

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 young people.

The SCU had 28 care staff. There was an acting unit manager and two acting deputy unit managers. All three were full time permanent staff. There was one full time temporary and nine full time permanent child care leaders. There were 14 acting child care leaders: three full time permanent, eight full time temporary, two part time temporary, and one permanent relief worker. There was one full time temporary childcare worker. When there were shortages of staff, the relief panel local to the four residential units in the area was used. Including managers, there were nine male staff and 19 female staff. The average age of the staff was 33 years. The staff worked in three teams lead by team co-ordinators. There were sufficient staff on duty on each shift to ensure that the young people received individual attention and could use the permission given by the case management team to go outside the unit.

All of the 17 HSU staff worked in rosters on the wing in Gleann Alainn where the young person in transition between the units was living. For much of the day the young person was either at school in Ard Alainn, the school established for the four local units including Gleann Alainn and HSU, or she was in HSU itself. However, she spent nights in Gleann Alainn, and the proportions of other time spent in each unit varied according to circumstances. The HSU staff group comprised: a full time permanent deputy manager, one part time temporary and three full time permanent child care leaders, three full time permanent and one part time permanent child care workers, four full time temporary child care workers, and two full time permanent and two full time temporary trainee child care workers.

4.2.2 Staff Checks

Twenty six of the 28 Gleann Alainn staff had Garda clearances. Twenty two clearances were received before the members of staff commenced employment. Ten staff had three references, 14 had two, two had one, and two staff had none. Of the 60 references received, 45 were received prior to staff commencing employment. Five references consisted of notes indicating that the manager had taken up a verbal reference over the phone. There was no evidence that these were followed up by confirmation in writing from the referee. One written reference and the notes of two verbal references had no date. In the HSU staff group 15 out of 17 staff had Garda clearances. Of the 15 checks received, 12 were received before the members of staff commenced employment. Only one member of this staff group had three references,

eleven had two, two had one, and three staff had none. Of the 25 references received, 23 were received prior to staff commencing employment. Four references consisted of notes indicating that the manager had taken up a verbal reference over the phone. Two of the verbal references had no date.

Inspectors found some deficiencies in the references. References for some of the staff in both staff groups pre-dated the start of their employment by periods of between one to seven years. Some of the references seen by inspectors were extremely brief and did not refer to the suitability of the candidate for the child care post applied for. It was not clear whether they had been pursued and questioned by those responsible for making appointments. Managers told inspectors that while testimonials sent in with applications were kept on the file, they were not regarded as references. The checks and references of some of the staff were not readily accessible to those with a legitimate reason to see them because they were kept elsewhere within other organisations in the board. The vetting documents for staff holding permanent posts were held in the Human Resources offices of the board. While it was board policy that the files of temporary appointments should have been kept in the units where they were employed, some of the staff had moved between residential centres and their files were still held by the centre that recruited them. Therefore, there was no facility for any individual or component organisation of the board to have an overview of the system of vetting for all of the staff, permanent and temporary, who had substantial access to young people.

Inspectors are of the view that the relevancy and timescales of checks and references should be given serious consideration, and systems put in place to ensure that the information contained in references taken up before employment is contemporary and relevant. The manager of each children's centre should be satisfied that Garda checks and references have been taken up for all the staff in the centre, and for others, such as chaplains and the staff from other centres who may be providing relief cover, who attend the unit and have regular contact with young people. The board should also satisfy itself that vetting procedures of all staff are appropriate and thorough by monitoring them on a regular basis.

The guidelines for vetting of staff are clear: Garda clearance and three references are required for all staff prior to the commencement of employment. The standard has not been met fully, and the systems used by the board need to be reviewed in order to reflect the requirements of the Department of Health and Children in respect of vetting of staff for children's centres.

Recommendations

2 The board should ensure that all outstanding Garda checks and written references for current staff at Gleann Alainn and HSU are sought.

3 The board should review its system of recruitment and vetting to ensure that the Department of Health and Children's guidelines for vetting staff before employment are followed in all future appointments of staff in children's centres.

4 The board should introduce regular monitoring of the vetting system in order to be assured that it provides the safeguards for which it was established.

4.2.3 Length of service and qualifications of staff

The average length of service of the Gleann Alainn staff group was just over two years and two months. In the HSU it was approximately one year eleven months. Six Gleann Alainn and five HSU staff had child care qualifications. Apart from the child care qualifications,

both staff groups had a wide range of academic achievements. The posts, length of service and qualifications of both staff groups is shown in the table below.

Gleann Alainn Staff – August 2003				
CARE STAFF		***Length of Service***	***Employment Status***	***Qualification***
#1	Acting Manager	3 years 2 months	Full Time Permanent	BA Applied Social Studies Diploma in Applied Social Studies
#2	Acting Deputy Manager	3 years 2 months	Full Time Permanent	BA English and History Higher Diploma in Education
#3	Acting Deputy Manager	2 years 10 months	Full Time Permanent	BA Psychology and Sociology
#4	Child Care Leader	3 years 5 months	Full Time Permanent	Diploma in Montessori Education
#5	Child Care Leader	3 years 4 months	Full Time Permanent	No qualification
#6	Child Care Leader	2 years 11 months	Full Time Permanent	BA Psychology and Sociology
#7	Child Care Leader	2 years 10 months	Full Time Permanent	National Diploma in Applied Social Studies in Social Care
#8	Child Care Leader	2 years 7 months	Full Time Permanent	National Diploma in Applied Social Studies in Social Care
#9	Child Care Leader	1 year 11 months	Full Time Permanent	National Diploma in Applied Social Studies in Social Care
#10	Child Care Leader	1 year 4 months	Full Time Temporary	Registered Nurse
#11	Child Care Leader	7 months	Full Time Permanent	BA Psychology
#12	Child Care Leader	3 months	Full Time Permanent	Dutch Social Care Qualification
#13	Child Care Leader	2 months	Full Time Permanent	Certificate of Qualification in Social Work
#14	Acting Child Care Leader	7 years	Part Time Temporary	Registered Nurse
#15	Acting Child Care Leader	3 years 9 months	Full Time Permanent	BA in Social Science
#16	Acting Child Care Leader	2 years 7 months	Full Time Permanent	BA in Social Science
#17	Acting Child Care Leader	2 years 2 months	Full Time Temporary	Diploma in Social Studies
#18	Acting Child Care Leader	1 year 11 months	Full Time Temporary	National Diploma in Applied Social Studies in Social Care
#19	Acting Child Care Leader	1 year 10 months	Full Time Temporary	No qualification
#20	Acting Child Care Leader	1 year 10 months	Part Time Temporary	Diploma in Home and Farm Management
#21	Acting Child Care Leader	1 year 9 months	Full Time Temporary	Registered Nurse
#22	Acting Child Care Leader	1 year 7 months	Full Time Permanent	BA in Social Science
#23	Acting Child Care Leader	1 year 7 months	Full Time Temporary	No qualification
#24	Acting Child Care Leader	1 year 4 months	Full Time Temporary	No qualification
#25	Acting Child Care Leader	1 year 3 months	Relief Permanent	Registered Nurse
#26	Acting Child Care Leader	1 year 3 months	Full Time Temporary	No qualification
#27	Acting Child Care Leader	1 year 2 months	Full Time Temporary	No qualification
#28	Child Care Worker	1 year 2 months	Full Time Temporary	Degree in Law (?)
HSU Staff - August 2003				
#1	Deputy Manager	3 years 6 months	Full Time Permanent	No Qualification
#2	Child Care Leader	3 years 6 months	Full Time Permanent	BA & National Diploma in Applied Social Studies in Social Care
#3	Child Care Leader	3 years 6 months	Full Time Permanent	Diploma in Youth and Community Work
#4	Child Care Leader	7 months	Full Time Permanent	BSc in Social Science BA in Public Management MA in Social Work
#5	Child Care Leader	2 years 10 months	Part Time Temporary	BA Social Science
#6	Child CareWorker	3 years 5 months	Full Time Permanent	Diploma in Youth and Community Work
#7	Child CareWorker	3 years 3 months	Full Time Permanent	Diploma in Nursery Nursing
#8	Child CareWorker	1 year 4 month	Full Time Permanent	BA & National Diploma in Applied Social Studies in Social Care
#9	Child CareWorker	9 months	Part Time Permanent	National Diploma in Applied Social Studies in Social Care
#10	Child Care Worker	2 years 6 months	Full Time Temporary	Diploma in Youth and Community Work
#11	Child Care Worker	2 years 4 months	Full Time Temporary	Diploma in Youth and Community Work
#12	Child CareWorker	2 years 2 months	Full Time Temporary	National Diploma in Applied Social Studies in Social Care
#13	Child CareWorker	10 months	Full Time Temporary	BA in Child and Youth Care *(Canada)*
#14	Trainee Child Care Worker	11 months	Full Time Permanent	BA in English & Philosophy
#15	Trainee Child Care Worker	11 months	Full Time Permanent	Diploma in Nursery Nursing
#16	Trainee Child Care Worker	7 months	Full Time Temporary	No qualification
#17	Trainee Child Care Worker	1 month	Full Time Temporary	BSc in Social Science MA in Social Work

4.2.4 Staff rota

The staff were divided into three teams of six, each one led by a team co-ordinator. A team arrived for work at 1.00 p.m. each day. There was a handover meeting lasting an hour with the team about to go off duty. The team covered for colleagues who were on annual and other leave, so there could be less than six on duty. The two staff who had been on sleep-in duty the previous night left at 1.30 p.m. The rest of the outgoing team left at 2.00 p.m. Another member of staff came on duty from 4.00 p.m. to 2.00 a.m. each weekday and from 1.00 p.m. to 1.00 a.m. each Saturday and Sunday. Night staff came on duty at 9.00 p.m. and after a handover period of about half an hour joined the other staff. Young people were expected to be in their rooms by 9.30 p.m. after checks had been carried out on their bedrooms. Bedtime was 10.00 p.m. Between then and 11.00 p.m. staff assisted any of the young people who found it difficult to settle. Bedroom doors were not locked overnight, but from 11.00 p.m. an alarm system was activated which reacted when anyone crossed the threshold of a bedroom. With the two waking night staff there were also two sleep-in staff drawn from the team. The rest of the team left at 11.00 p.m. Night duty finished at 8.00 a.m. the following morning.

4.2.5 Staff supervision and support

The inspection report of April 2000 recommended that the board ensure that individual supervision should be regular and guaranteed. In the following year inspectors recommended that the acting unit manager should ensure that all staff receive regular formal individual supervision. In 2002 inspectors recommended that the system of supervision be tightened so that all staff receive it on a consistent basis, preferably at monthly intervals.

In this inspection inspectors found to a large extent these recommendations had been met. The acting unit manager received monthly supervision from the child care manager once a month. The unit's policy stated that staff should receive supervision individually once per month, and that there was group supervision of each of the three teams once per month.

Staff told inspectors that there had been an improvement in the area of supervision. Efforts were made to ensure that it happened, and although it covered areas where learning was needed it was also affirming. The group supervision sessions were described as arenas in which team issues could be discussed professionally. One of the acting deputy managers had completed a supervisors' course, and was offering the groups and most of the staff individual supervision. The same deputy was due to take over the management of the unit on the transfer of the incumbent of the post, and would not be able to provide the same level of supervision. Gleann Alainn had entered into a joint supervision training initiative with the new special care unit in Limerick, and the three team co-ordinators were scheduled to attend a supervisors' course in October 2003. Thereafter, they would supervise the individual staff members in their respective teams.

There were no supervision contracts, but an agenda was set in advance of each meeting, and group supervision dealt with issues such as accountability and support while individual supervision focussed on the more clinical aspects of the work. Inspectors commend the unit managers for the efforts made to provide comprehensive supervision to staff. They suggest that the system introduced could benefit from further refinement. For example, supervision contracts should be drawn up, and supervisees should be required to sign each record of their supervision.

Staff told inspectors that there were meetings of the whole staff team once a week. The book containing the minutes of the staff meetings did not reflect this. There were handover meetings supported by summary sheets giving a clear account of the previous shift to the team coming on duty.

The unit had access to a senior clinical psychologist who served four residential centres including Gleann Alainn. He was appointed to this post in April 2002. His role was to carry out assessments and provide consultancy to staff. Until a short time before the inspection the staff at Gleann Alainn were not able to refer a young person directly to him. Managers told inspectors that from the time of the inspection onwards they would. Their understanding of the purpose of the psychological service was that it should benefit both young people and staff. The purpose of the post was to add to the understanding of the young people and contribute to the review process, as well as working with staff groups in order to enhance their understanding of their role in the lives of the young people.

The board had an employee assistance scheme that offered a confidential counselling service to staff. As well as taking self-referrals, the scheme also took referrals from the managers of children's centres, and had been accessed from time to time by staff in Gleann Alainn.

There were monthly meetings of managers of children's centres.

Managers told inspectors that on call cover had been provided jointly by the managers of Gleann Alainn and the HSU, but the arrangement ceased at the beginning of September 2003. The arrangement at the time of the inspection was that weekends from Saturday a.m. to Monday a.m. were covered by the acting unit manager and his deputies. Throughout the week one of the acting deputy unit managers provided a quick response service to staff in the evenings and overnight. They were able to contact him by phone at night. This was an informal arrangement put in place at times of crisis. Many of the staff interviewed by inspectors expressed appreciation of this level of support. Inspectors were told by the unit managers that there was a plan to give team co-ordinators on call responsibilities. The intention was that once they started providing the cover it would be formalised and remunerated.

The unit had also used outside facilitators as needed. The most recent occasion when a facilitator came to the unit to talk to staff about issues raised by a specific circumstance was in the early summer of 2003.

4.2.6 Staff training and development

The range of training undertaken by the Glenn Alainn and the HSU staff groups is shown in the table below. The majority of Gleann Alainn staff were trained in Therapeutic Crisis Intervention (TCI), but although several went to the briefing session on it, few had training in Children First. One deputy manager had been on a supervisors' course. There was one member of staff trained in First Aid, but there were also four qualified nurses on the staff. As indicated in 4.2.5 above there was a plan to send the three team co-ordinators on a supervisors' course.

The report of the inspection of Gleann Alainn in 2000 recommended that the unit undertake an audit of staff training needs in order to put together a training action plan. After that inspection staff received group training on eight occasions between September 2000 and April 2001, and there was a week of in-service training in November 2001. In this inspection managers told inspectors that the training needs of individual staff had been discussed, but there was no comprehensive audit or action plan for on-going training as recommended.

The audit should cover what is generally needed to deliver the service in the unit, and the training needs of individual staff. Inspectors recommend that all staff receive training in

safeguarding and Children First, and that those still in need of training in TCI receive it. They also recommend that the unit increases the number of staff trained in first aid, and provides training on fire and health and safety.

Staff Training at Gleann Alainn Special Care Unit - August 2003

		TCI (5 days)	*TCI Refresher Training*	*In-service Training (5 days)*	*Children First*	*Drugs and Alcohol*	*Staff Supervision*	*First Aid*	*Fire and Safety*	*Court Reporting Skills*	*Courtroom Skills*	*Bullying*	*Self Harm*	*Best Practice*	*TCI Trainers Course*	*Healthy Eating*	*Sexualised Behaviour*	*Traumatised Children*	*Therapeutic Child Care*	*Grief Counselling*	*Children's Rights*
Training of Gleann Alainn Staff - August 2003																					
1	Acting Manager	√		√	√						√			√				√			
2	Acting Deputy Manager	√	√	√			√						√	√				√			
3	Acting Deputy Manager	√	√	√									√	√							
4	Child Care Leader	√	√	√															√		
5	Child Care Leader	√	√	√																	
6	Child Care Leader	√	√	√																	√
7	Child Care Leader	√	√	√																	√
8	Child Care Leader	√	√																		
9	Child Care Leader	√	√	√										√							
10	Child Care Leader																				
11	Child Care Leader	√	√	√																	
12	Child Care Leader	√																			
13	Child Care Leader	√	√	√																	
14	Acting Child Care Leader	√	√	√																	
15	Acting Child Care Leader	√		√																	
16	Acting Child Care Leader	√	√	√																	
17	Acting Child Care Leader	√	√	√																	
18	Acting Child Care Leader	√	√	√				√													
19	Acting Child Care Leader	√		√																	
20	Acting Child Care Leader	√	√	√				√						√							
21	Acting Child Care Leader	√																			
22	Acting Child Care Leader	√		√																	
23	Acting Child Care Leader	√		√																	
24	Acting Child Care Leader	√	√	√																	
25	Acting Child Care Leader	√		√																	
26	Acting Child Care Leader	√	√	√																√	
27	Acting Child Care Leader	√	√	√																	
28	Child Care Worker																				
Training of HSU Staff - August 2003																					
1	Deputy Manager	√			√		√			√			√								
2	Child Care Leader	√			√	√		√													
3	Child Care Leader	√					√	√	√	√		√			√						√
4	Child Care Leader	√			√							√									
5	Child Care Leader	√				√															
6	Child Care Worker	√			√																
7	Child Care Worker	√			√				√												
8	Child Care Worker	√																			
9	Child Care Worker	√				√															
10	Child Care Worker	√			√	√										√					
11	Child Care Worker	√				√		√													
12	Child Care Worker	√			√				√								√				
13	Child Care Worker	√						√	√												
14	Trainee Child Care Worker	√																			
15	Trainee Child Care Worker	√				√		√													
16	Trainee Child Care Worker							√													
17	Trainee Child Care Worker	√																			

Training in TCI includes individual crisis management plans (ICMP), which is a form of risk assessment. The unit has also introduced a generalised risk assessment procedure.

As indicated in 4.4.5 below, training in the assessment and management of risk should be provided in association with the training on safeguarding. The audit of training needs and

production of a training action plan, as recommended by inspectors in 2000, should be carried out. Inspectors suggest that the managers of the unit consider making further training in sexualised behaviour, the impact of drugs and alcohol, self-harm, and children's rights available to the Gleann Alainn staff group.

The HSU staff working in the unit had received a different range of training as shown in the table above. In part, this was possible because training was an integral part of the reorganisation of the high support unit, and the moratorium on referrals provided an opportunity to respond to the staff group's training needs.

Recommendations

5 The board should ensure that all staff in Gleann Alainn be trained in TCI, safeguarding and Children First.

6 The board should increase the number of staff trained in first aid, and provide training on risk assessment and risk management, fire safety, and health and safety.

7 In accordance with the recommendation made in the 2000 inspection, the managers of the unit should audit the training needs of Gleann Alainn staff, and produce a training action plan.

4.2.7 Unit Management

The unit is effectively managed and staff are organised and deployed so as to operate the unit effectively and efficiently to the required standard.

The unit was effectively managed by the acting manager and his deputies. Staff, parents and professionals interviewed by inspectors spoke well of the managers of the unit, particularly about the style of leadership which reduced to the minimum the sense of 'us and them' between the staff and young people. The team co-ordinators spoke approvingly of the degree of autonomy they were given to run the shifts covered by their teams. This was evident on one of the days of the inspection when a team decided to reverse a decision about a young person's outing after carrying out a risk assessment. The process required consultation with all the staff on duty, and the team co-ordinator recorded the reasons for the decision made on a form designed by unit staff. The group supervision referred to in 4.2.5 above was seen by staff as a means to develop team identity, and provided managers of the unit with an added means of communication with the teams over and above the staff meetings.

4.2.8 Monitoring

The unit had been visited regularly by the child care manager in order to meet the requirement of *Child Care (Placement of Children in Residential Care) Regulations, 1995, Section 17.* It was not ideal, nor within the letter of the standards, to combine this role with that of direct line management of the acting unit manager. However, in the absence of an appointed monitor the functions of an authorised person, as described in Section 17 of the regulations, were fulfilled. Inspectors acknowledge the role of the child care manager in visiting the centre and discussing with the manager issues that came to his notice during his visits.
The issues discussed were seen by inspectors in a written record of the visits kept by the unit. The record showed that visits had taken place on an average of every two to three months

since October 2000. On occasion the child care manager was accompanied on the visits by the general manager.

In order to comply with the standards, the board had appointed two monitors. At the time of the inspection they were in transition from their old to their new posts. One of them was the acting unit manager of Gleann Alainn, and the other was a member of the management committee of the unit. They were due to be fully in post by November 2003. Their line manager will be the child care manager of another community care area in the board who does not have direct line management responsibility for residential services.

Inspectors welcome the appointment of the monitors, and recommend that they produce a programme outlining a proposed schedule of monitoring of the unit. Their monitoring function should include checks on whether staff are appropriately vetted, and whether each young person in the unit has a care plan. Inspectors advise the newly appointed monitors produce an outline proposal of how they are going to monitor the SCU as soon as possible, and to ensure that there is clarity about the requirement of the standards for all significant events to be routinely notified to them.

4.3 Planning for young people

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

4.3.1 Referral and placement of young people

As shown in 3.3 above, the management structure of the unit included a referrals and admissions committee. Its function was to appraise referrals to the unit and approve admissions. This function extended to the two high support units and the children's residential centre in the locality. It was chaired by the psychologist associated with the unit, and included the acting unit manager, and a deputy acting unit manager. The acting unit manager told inspectors that the MWHB and the SEHB had been invited to nominate representatives to sit on the committee. The committee met whenever there were referrals to consider.

A policy statement on the legal requirements for admission said that admission to the unit is by application for wardship proceedings by the relevant health board to the circuit court. The application for wardship should follow acceptance of the referral by the admission and discharge committee. The policy said that the SHB would be party to applications made by other boards. It also said that at wardship hearings separate representation must be appointed for each young person.

Inspectors found that at the time of the inspection the young people referred to the SCU by the SHB only were subject of wardship orders. The young people from the MWHB and the SEHB had detention orders from the high court. The use of wardship orders was explained by the managers of the unit as a response to legal advice. It was also explained in terms of the convenience of attending hearings locally in Cork rather than going to the High Court in Dublin. Inspectors were concerned about the implications of the orders in terms of the transfer of rights from the parents of the young people to the court.
Managers of the board were aware of such implications and had made arrangements and paid for legal representation for parents. However, inspectors found that while they acknowledged

that they were facilitated to put their point of view forward to the court, and while they were in favour of the placement, some parents did not feel that they really had a say about decisions concerning their daughters within the forum of the court.

At the time of the inspection there were two young people awaiting admission to the unit. Their referrals had been processed and approved by the admissions and discharges committee. Managers told inspectors of difficulties in moving young people on from the unit that had an impact on the ability of the unit to take new referrals. In particular, there had been chronic problems in transferring young people placed by the SHB from the SCU to the high support unit. The problems concerned issues that arose in the high support unit, and at the time of the inspection the board was in the process of reorganising the unit in order to address them. During the three month period of reorganisation the board declared a moratorium on admissions to the HSU.

In December 2002 one of the young people who had transferred to the high support unit was readmitted to the SCU. She was still resident in the SCU at the time of the inspection. In order to maintain her links with the HSU she was looked after by HSU staff in a suite of rooms at the SCU. The result of this arrangement was that the SCU could not admit young people up to its full capacity even though the admissions and discharge committee had approved referrals. At the time of the inspection there were two young people waiting for admission, and some facilities in the unit, such as the gym, were not available to young people in the SCU. The reorganisation of the high support unit had a further impact on the admissions to the SCU in that young people at the end of their planned period of detention in the SCU were unable to move into the step-down unit.

Managers are advised by inspectors to broaden their consideration of the issues involved in moving young people on from the SCU, and increase the options available to the referring social workers. The HSU could perform a step down function for some young people, but it may not be appropriate for every young person placed in the SCU. There needs to be clarity for young people, their families and the staff at Gleann Alainn about how long the young people will be detained in the unit, and where they will move on to once the short-term period of detention is over. There is urgency in addressing this matter. With the implementation of the Children Act 2001, a necessary part of the procedure for boards wishing to apply to the court for a special care order will be a family welfare conference, and consideration will have to be given as to how a high support unit might feature in the range of options available to a family welfare conference when it is looking at alternatives to special care. Even when the court grants a special care order it will be of shorter duration than most of the previous detention orders, and a more rapid movement of young people into a wider range of post-special care unit placements will be required.

Recommendation

8 As a matter of priority, the board should review the options available to meet the need of the SCU for regular step down placements.

The unit kept a register. It showed that during the year prior to the inspection there had been ten admissions. Nine of them were described as short term. One was described as respite. Three had been re-admissions from the HSU. For two of the young people it was their second re-admission from HSU. Four of the young people had been subject of high court detention orders. The others were detained in response to directions made under wardship orders from the local circuit court in Cork.

The register was a hard-back book in printed format. It recorded details in accordance with the *Child Care (Placement of Children in Residential Care) Regulations, 1995 Part IV, Section 21 (2).* It also recorded the date of a proposed discharge and destination, and an actual date of discharge and the place to where the young person was discharged.

There were entries showing when re-admissions had taken place. The register was replicated in an electronic format in an administrative office of the board. However, there were some discrepancies between the two records. One young person was registered as being subject of a wardship order rather than a high court detention order; and the electronic record showed proposed dates and places to which young people were discharged as though they were the actual ones. These are minor difficulties that should be easily remedied.

4.3.2 Care Plans

The inspection report of April 2000 recommended that the board ensure that written care plans be produced in line with the recommendations of the *Child Care (Placement of Children in Residential Care) Regulations, 1995 Part IV, Section 23.* In the following year inspectors recommended that principal social workers ensure that care plans are prepared for the young people in Gleann Alainn, preferably prior to admission. In the 2002 inspection report the recommendation was that, *"the relevant health boards should review the format used to devise statutory care plans. They should include evidence that parents and young people are consulted. They should be dated, signed by all, including parents and young people, and updated to reflect changes in circumstance, including re-admissions to the unit. Minutes of statutory review meetings should be made available to the unit and held on care files."*

At the time of the 2003 inspection this recommendation had not been fulfilled. Inspectors found that the standard on statutory care planning had not been met. In the unit's files there were care plans for three of the six young people. Two of the others did not have care plans, and the plan for another consisted of minutes of a care planning case conference held two weeks before admission at which is was decided to apply for a place in the SCU. The three care plans seen by inspectors were produced between one week and one month prior to admission in accordance with regulations.

They were of mixed quality. Two of them gave no indication of consultation with parents or care staff. Only one of them indicated the proposed plan after SCU placement. The arrangements for implementation of the plan were vague in one care plan, and missing in the other two. There was no evidence that plans were changed to reflect major changes in circumstances, such as being re-admitted to the SCU from the HSU. In one instance, where the care plan was incomplete, it was complemented by a more detailed placement plan drawn up by the staff of the SCU which indicated the arrangements for review. However, even this plan was unsigned and undated, and the three care plans did not have the signatures of parents and young people in the allotted spaces on the forms. In another file of a young person without a care plan there was a placement plan drawn up on the day of admission. It recorded the proposed discharge date, but did not have any record of decisions, and was unsigned.

The child care manager told inspectors that little progress had been made in addressing the recommendations of previous inspection reports even though he had written to the boards specifically asking for a review of the care plan format. The SCU had devised its own format for placement plans and reviews in order to respond to SSI recommendations regarding the inadequacy of care plans.

Inspectors are seriously concerned that recommendations on statutory care planning have been made annually for the last three years without effect. Inspectors recommend that the boards responsible for referring young people to the SCU support the SHB in complying with the regulations and standards by fulfilling their own statutory obligation to ensure that care plans are prepared.

4.3.3 Reviews

Managers told inspectors that there was a statutory review every month. The schedule of reviews was set at the first meeting of the case management team for each young person when the placement plan was drawn up. To bring practice into line with the anticipated implementation of the Child Care Act 2001, the first meetings of the case management team set a discharge date at three months from the date of admission and decided on the dates of monthly reviews. To the extent that they were chaired by social work team leaders and attended by the young person and those who constituted the case management team as described in 3.3 above, they served as statutory reviews.

However, inspectors found that even where care plans had been prepared there was confusion about whether the reviews were of them or the placement plans. The unit had devised a form for statutory care plan reviews, but in practice it was used to review placement plans. Several of the placement plan reviews made no reference to a care plan, even where one had been prepared. The majority were based on written reports from the young person and keyworker. There were no written reports from social workers or from those providing education. The forms were incomplete. Some did not record decisions and timescales for action. Some were incomplete and unsigned, and did not give an indication of minutes being received by the participants.

Parents interviewed by inspectors said that they received the reports prepared by keyworkers, but not the minutes of the review meetings. They assumed that they did not receive minutes because they had attended the meeting.

The case management team is a valuable innovation and its formation, along with the introduction of planning and review forms by the unit represent progress in making review meeting regular and consistent. Nonetheless, its role must be clear. The responsibility for formulating care plans and ensuring that they are properly reviewed rests with the supervising social worker. The placement plan should be the basis for implementation of the care plan rather than its formulation. Since it focuses primarily on the care of the young person in the unit it cannot serve as the statutorily required plan. There needs to be clarity about the monthly review meetings, and those in which the statutory care plan is reviewed should be clearly distinguished from those which simply review the placement plan. Other reviews of the case of the young person, such as the reviews of wardship in the courts or child protection case conferences, do not relieve the social worker of the duty to prepare a care plan and review it in accordance with regulations.

Inspectors acknowledge and commend the quality of the work done by the unit to introduce regular and consistent reviews. However, they recommend that along with the reforms necessary to bring care plans into line with the regulations, the referring boards should ensure that statutory reviews are clearly distinguished from placement plan reviews, and that as well as being held at frequent intervals they should also be held when circumstances dictate that a change in the care plan has become necessary, as for example, in the case of the breakdown of a placement at a step-down unit.

In order to achieve the standard for care plans and care plan reviews there needs to be:

- a reform of practice in social work teams in relation to the preparation and review of statutory care plans;
- a common expectation in the three boards using the SCU that social workers prepare detailed and completed statutory care plans prior to admission, and produce written reports for reviews;
- a strict adherence to the requirement of the admissions and discharges committee that each referral to the SCU is accompanied by a completed statutory care plan that identifies a discharge and aftercare placement;
- clear evidence in the statutory care plan of consultation with all parties, but particularly with young people, parents and care staff;
- prominence in the individual care files held at Gleann Alainn for all documentation connected with the statutory care planning process, and separation of the placement plans from the statutory care plans so that there is no scope for assuming that placement plans function as care plans; and
- regular checks by managers and monitors to ensure that statutory care plans and statutory care plan reviews are of an acceptable standard.

Recommendations

9 As a matter of the highest priority, the managers of the MWHB, SHB and SEHB should develop a common protocol to ensure that each young person placed in Gleann Alainn has a completed care plan at the time of admission.

10 The social workers of young people currently in the SCU without care plans should ensure that plans are prepared and copies given to the unit, the young people and parents as soon as possible.

11 The managers of the board and monitors of residential centres should introduce a system of regular checks to ensure that care plans and care plan reviews conform to the requirements of the regulations and standards.

4.3.4 Contact with families

The unit gave a high priority to contact with families. Unless access had been determined already by the court, the case management team for each young person in the unit decided on the arrangement and frequency of contact.

Case management teams met once a month, but had telephone contact with each other between times as the need arose. Their remit was to formulate a placement plan, and to make decisions about home access, contact with friends, and attendance at external schools. They also made decisions about risk assessments and mobilities, that is, to determine under what conditions and how frequently a young person may go outside the unit. At their monthly meetings the case management team reviewed the placement plan.

The SCU staff facilitated contact by providing most of the necessary transport. Parents and social workers commended the unit staff for their assistance with transport. This commitment entailed long journeys each week in order to cover more distant parts of the region. In one part of the unit there was a visitors' room with soft furnishings where, subject to any requirement for supervision, young people could meet their families in private. The unit also endeavoured to re-establish contact where it had lapsed, and ensured that even those parents

who had circumstantial difficulties in maintaining contact were kept informed of their children's progress by sending minutes of review meetings.

The access and contact arrangements were discussed at each monthly placement plan meeting. Access for some of the young people was either prohibited or, from time to time, supervised. The supervision of visits was decided on the basis of risk assessments carried out by the staff teams. The decision of the staff to have certain access visits supervised was brought to the case management team for approval. The unit devised lists of people that an individual young person could not contact, but in exceptional cases it was a list of contacts only. Some decisions were made on the basis of the circumstances of an individual case while others were based on a general rule of the unit.

Inspectors were impressed by the pragmatism shown by unit managers and staff both in facilitating contact and in having the flexibility to use and withdraw supervision as necessary by linking it with an assessment of risk. The use of the case management team also ensured that the members of the social work team, other professionals, parents and the young people themselves were directly involved in decisions about access.

4.3.5 Legal and court work

The use of wardship orders rather than detention orders for young people placed at the SCU by the SHB is referred to in 4.1.2 above.

Young people placed by the MWHB and SEHB were subject of detention orders from the high court. All young people in the unit had legal representation, and two of them had guardians-ad-litem. One young person, whose parents were not party to court proceedings and were not involved in the decisions regarding her care, did not have a guardian-ad-litem. Inspectors are of the view that there is a case for considering the appointment of a guardian-ad-litem for her. Communication with solicitors and attendance at court were key areas of responsibility for managers and staff at the unit. The solicitor who represented the SHB in wardship proceedings was included in notifications of significant events such as unauthorised absences.

4.3.6 Supervision and visiting of young people

Inspectors interviewed all the social workers of the young people in the unit. Their visits to the unit varied between fortnightly and monthly. They also saw the young people when attending court for the renewal of orders and at the monthly placement plan review meetings. They were able to see the young people in private in the unit, but they preferred to take them off site. None of the social workers had read the care records of young people from time to time in accordance with the regulations. Inspectors urge them to do so in order to satisfy themselves that the young people are safe, their rights are being promoted, and they are receiving a high standard of care.

Recommendation

12 Principal social workers in the referring boards should ensure that supervising social workers read care records in the unit from time to time in accordance with the regulations and standards.

4.3.7 Preparation for moving on

The unit managers told inspectors that it was an expectation that exit plans would be in place for each young person at the point of admission to the unit. For the young people placed by the SHB the plan on leaving Gleann Alainn was that they should always transfer to the HSU as a step-down from a special care unit. The difficulties in effecting this transition for several of the young people are referred to in 4.3.1 above.

After care plans were in place for only three of the young people resident in the unit at the time of the inspection. One was in transition to the HSU, and had met the after care worker of the SHB once. The after care plan was not written into a review of the care plan. For another young person, not from the SHB area, the plan had been drawn up at a case conference. For another young person there was a plan that a parent had concerns about, and the social worker was looking at alternative placements fore her.

Inspectors commend the unit's requirement for exit plans to be in place at the point of admission, and urge referring social workers meet it. It emphasises the necessary brevity of placements in the unit, and ensures that special care is not seen as standing outside the context of a continuum of care for the young person. With the implementation of the Child Care Act 2001 there will be pressure on referring boards to ensure that the loss of a young person's liberty in a special care unit is kept to an absolute and clearly accountable minimum.

4.3.8 Emotional and specialist support

The unit's policy documents did not include a written policy on keyworking. Staff told inspectors that the role was learnt by word of mouth from longer serving colleagues and through experience. Inspectors have been informed since the inspection that the deputy unit manager with responsibility for supervision had distributed to the teams a handout outlining the keyworker role. Each young person had two keyworkers. The main aspects of the role were described as: developing a relationship with an individual young person, working with families, improving skills in recording and court work, liaising with other professionals, and having individual time with young people. Staff told inspectors that they were nominated as keyworkers for a young person as soon as the admission was approved. They were involved in visiting and establishing links with the keyworkers in previous placements so that transition to the SCU could be as smooth as possible. They had a practice of being in the unit when the young person was admitted so that she would meet someone she was familiar with, and some keyworkers were involved in searching a young person and explaining the rules and procedures of the unit at the point of admission, even at times coming in when they were off duty to do so. They also assisted in transition from the unit to post-SCU placements, and visited young people for a short while after they had left.

Time for the individual sessions was afforded by the staff rota, and often keyworkers took young people off site. Staff said that the placement plans were useful tools in setting an agenda for the direct work done in keyworker time. Sexual health was an area that staff focussed on in order to address the needs of several of the young people. They received support in providing appropriate information and guidance from the local health promotion unit. One person came to the unit and spoke to staff, and another offered individual sessions to individual young people. The progress of keyworking sessions was discussed in individual staff supervision. Keyworking sessions were recorded in the young people's individual logs.

Inspectors interviewed the senior clinical psychologist associated with the centre. He was appointed in May 2002 to provide a psychological service to the special care unit, the two high support units, and one other residential provision. He had been closely involved with one young person who was undergoing transition from Gleann Alainn to the local high

support unit over a period of months after a previous attempt to make the transition had failed. He chaired the admissions and discharges committee which processed referrals to the same four local residential centres.

The 2002 report recommended that the SHB address the provision of psychiatric services to young people in Gleann Alainn, irrespective of their age or placement source. In this inspection, inspectors found that the recommendation of the 2002 report had not been met, and that the position in relation to accessing psychiatric services remained unsatisfactory.

Managers of the unit said that there were fewer young people in need of psychiatric intervention than there had been in the previous year. However, the position remained as it was in 2002. Young people from the SHB area could access the local service up to the age of 16. If they were referred before reaching the age of 16, and therapy was necessary beyond then, they could continue to receive it up to their 18th birthday when they would pass over to the adult services. If they were referred between the ages of 16 and 18 there were difficulties in accessing services. Child and adolescent psychiatrists would not take referrals for young people after the age of 16. The local psychiatric service did not take referrals of young people from the MWHB and SEHB areas, and the psychiatric services from their own home areas did not take referrals of young people placed in Gleann Alainn because they were not resident in their area.

Inspectors are concerned that despite recommendations being made over two consecutive years this unacceptable situation remains and there is a serious deficit in the service provided by Gleann Alainn to some of the most vulnerable young people in care. With the implementation of the Children Act 2001, and the consequent shorter periods of detention envisaged by the Act young people in need of assessment or treatment will need to access local services without delay. The 2002 report described the services as cumbersome and fragmented. The services should be characterised by multi-disciplinary partnership and flexibility in response to need. The problems experienced by the unit in meeting the psychiatric needs of the young people in their care run counter to the concept of a specialised and integrated regional service. Inspectors are aware that this is a subject of national discussion, but there is an urgent need for the three referring boards to resolve the issues preventing the young people in Gleann Alainn accessing an appropriate service. The unit requires such access in order to meet the standards now, and particularly when the Children Act 2001 is implemented.

Recommendation

13 In line with recommendations made in 2001 and 2002, inspectors recommend that the managers of the MWHB, SEHB and SHB give the resolution of the problems in providing a psychiatric service to the young people in Gleann Alainn the most urgent attention.

4.3.9 Young people's case files

The inspection report of 2000 recommended that files kept in Gleann Alainn *"should be harmonised with records held by social workers. In particular, these should consistently contain a written care plan, birth certificate, and a complete record of visits by social workers and parents."* It also recommended that Gleann Alainn should issue written guidance to staff about maintaining files.

The policy document prepared the SCU had a brief policy on record keeping. It covered the completion of personal logs, and emphasised that young people have access to them, should sign them, and should be encouraged to contribute their own views in writing to them.

Each young person in the SCU had three files and a personal log. The first file covered legal matters, social work, psychology, psychiatry, and education. The second was for care plans, placement plans, reviews, incident reports, complaints, single separation, and restraints. The third contained information on medical matters.

In the files of six young people examined by inspectors there was only one social history. It accompanied a social work report. Managers explained to inspectors that although social histories are required by the regulations and by the unit's own admissions and discharges committee, they were rarely received because court reports outlining the history of the young people were accepted instead. However, inspectors found only one court report that served this dual function. School reports were found on one file only. One file did not have a copy of the court order, but a copy of the order was acquired and later shown to inspectors. Four files did not have birth certificates. The acting unit manager told inspectors that the unit had encountered difficulties in getting three of them, and in the case of one young person some of the documentation required by the regulations had been transferred to her file in the HSU without copies being kept at Gleann Alainn. Only three files had care plans and care plan reviews. These are referred to in 4.3.2 and 4.3.3 above. Social work visits were discretely recorded in three of the files. The medical files contained details of GP appointments, prescription sheets and records of the administration of medication. However, none had evidence of medical examinations carried out at the point of admission to the unit, or a record of the board's decision that a medical report was not to be sought, as required by regulations.

The unit has produced several forms of good quality to support the staff in recording. The forms for risk assessments, notification of significant events, placement plans and placement plan review forms were particularly well designed. The unit had also developed a common policy with the SCU at Coovagh House in Limerick to request from referring social workers several documents in support of the application for a place at the unit, including a social history, educational history and psychological assessment. Inspectors welcome this development, and advise that a medical history is added to the list. Inspectors found that the records of TCI and the use of physical restraint were detailed and clear. Other records were less well maintained. For example, a record of return from an unauthorised absence did not indicate whether the social worker was informed. Several records were unsigned and/or undated. There was a record of single separation in one file that did not have a proper record of the observation schedule. There was a space for weekly reports, but these were intermittent on most files, and though they were designed to be read and signed by the young person, most were signed by the keyworker only.

The standard for young people's individual care files was not met. Inspectors found that the care planning process and the documents required by regulations did not have the same prominence in the files as the reports and correspondence relating to the legal processes. In order to achieve the standard there needs to be:

- a review of the system of maintaining individual records, as recommended in the 2000 inspection, to ensure that they are harmonised with those of social workers and that all documentation required by the regulations is contained and kept in them;
- detailed written guidance for staff to supplement the policy on record keeping, which enshrines the principle of professional accountability in all the records, - therefore, that all are contemporary, complete, dated and signed by the author;

- integration of the personal log and the files through clarity about which records are within the log, and which require discrete records in the individual file, and a system of cross-referencing between them that promotes ease of access to information while avoiding duplication;
- a strict adherence to the requirement of the admissions and discharges committee that each referral to the SCU is accompanied by a social history, care plan, and the other documentation identified by the committee;
- as indicated in 4.3.3 above, prominence in the individual care files for all documentation connected with the care planning process; and
- regular checks by managers and monitors to ensure that the recording system is of an acceptable standard, with a place in the file to register the checks.

Recommendations

14 In accordance with the recommendations of the 2000 inspection report, the board should ensure that all files are harmonised with those of social workers, and contain all the documentation required by the regulations.

15 The acting centre manager should review the SCU's system of individual care records and produce detailed practice guidance for staff on the production and maintenance of them.

16 Managers and monitors should carry out regular checks of the recording system in the SCU to ensure that they are of an acceptable standard.

4.4 Care of young people

4.4.1 Relationships between staff and young people

Young people are cared for by staff who can relate effectively to them.

All the young people, parents, social workers, and professionals associated with the centre spoke highly of the quality of the relationships between the staff and young people. The relationships were said to be characterised by respect on the part of the staff, and trust on the part of the young people. Inspectors were impressed by the sensitivity shown in interactions with the young people, and by the general good sense of humour between the staff and young people that pervaded the unit during the inspection. One young person, who had been at the unit for a long period, told inspectors, "It's more the staff than the building. They have been there for me. They never hold grudges, no matter what I do. They will listen and take you at your word. I definitely trust them."

4.4.2 Quality of care

Day to day care is of good quality and provided in a way that takes account of the individual needs of young people in relation to age, race, culture, religion, gender and disability.

Day to day care in the unit was of a high quality. The young people interviewed by inspectors did not make reference to the fact that they were in detention, or that being in a SCU impacted on their ability to get out into the community and engage in appropriate activities. They spoke highly of the acting manager and staff, and those who had been there for long periods spoke warmly about their keyworkers.

They could identify staff that they felt able to confide in and trust. They said that their views were taken into account, and that they were able to disagree with staff, for example during the preparation of a court report, and have their point of view respected.

The unit had a policy on religious observance. It said that while the unit supported the young people in having opportunity to attend services and receive support in their particular faith, safety issues take precedence over attendance at religious services. In practice, the unit facilitated young people attending church under supervision if they wished to go, and there was a chaplain who visited the unit once a week to be available to offer spiritual advice to young people if they requested it. Staff told inspectors that if a young person could not go out because of safety considerations and they wished to attend mass, arrangements would be made to hold mass in the unit. They also said that one young person from a minority Christian denomination used to be collected from the unit by members of the local congregation in order to attend services. Only one of the young people's files recorded their religion. Referring social workers did not make the unit aware of parents' wishes regarding their children's religion. Inspectors are of the view that the unit's policy on religion needs to be developed further to include the requirement to consider the wishes of parents, and to cover the provision of instruction in religion as well as attendance at services.

Recommendation

17 The unit managers and staff should develop further the policy and practice on religion.

4.4.3 Rights of young people

Young people are cared for in a manner that safeguards and actively promotes their legal and civil rights.

4.4.3.1 Access to information

The unit did not have specific written policy or practice guidelines for staff on access to information. In the policy on record keeping there was a statement that children have a right of access to their personal logs that would normally be facilitated during keyworker sessions. The child should sign the log and be encouraged to contribute their views in writing. However, inspectors found on interviewing staff about the role of the keyworker that facilitating access to information did not feature as a standard practice. Some of the young people were aware that they could read their personal logs, but chose not to. One young person said that she was involved in the preparation of her court reports; and the files showed that all of them were facilitated in filling forms in preparation for review meetings. The SCU's young people's information booklet does not have any reference to access to information, and it does not explain how young people can see their personal logs or files.

Inspectors are of the view that the standard in respect of access to records was not completely met, and that further work is needed to develop policy and practice in the unit and to promote and facilitate access to files as well as personal logs.

4.4.3.2 Consultation

The unit had a brief written policy on children's rights. It listed ways in which the views of young people in the unit were sought. They included a weekly house meeting, active

involvement in planning menus, shopping, and purchases of special equipment, consultation about activities and about unit décor, and facilitating the girls in contributing to their reviews.

The young people interviewed by inspectors felt that their views were sought about their daily lives and about their future. Inspectors found that the policy was reflected in practice, and that the standard was met.

4.4.3.3 Complaints

The SCU had a clear and thorough complaints policy which stated that all children had the right to complain, and to be listened to and taken seriously. It also said that all complaints and allegations should be dealt with thoroughly and promptly and the child and her family should be informed of the outcome. The procedure referred to in the policy statement was that where possible staff on duty would deal with complaints, and where this was not possible the child should complete a complaint form.

In practice, young people were told how to make a complaint on admission to the unit. At the time of the inspection the complaint form had been revised after consultation with parents and social workers. The new form had a front sheet that explained how a complaint could be made. Staff interviewed by inspectors had a clear understanding about the difference between a complaint and an allegation of abuse, and understood that child protection concerns had to be notified to the principal social worker and child care manager.

In the year prior to the inspection there had been one complaint made by a young person after an episode of restraint in July 2003. The incident took place outside the unit when the young person was at the HSU. It was processed by Gleann Alainn staff in accordance with its policy. It had been sent to the social worker, and to the child care manager who made a decision to appoint a manager of a SHB residential centre unconnected with Gleann Alainn and HSU to carry out an investigation into the complaint. The unit is commended for the way in which this arrangement was made in the absence of any written protocol for dealing with complaints that concerned more than one residential centre. Since the complaint arose from the use of physical restraint a copy was also sent to the board's TCI co-ordinator in order to ensure that the application of TCI used in the incident was consistent with policy and training.

The written policy did not include information for young people on how to appeal a decision if it was felt that the outcome was unsatisfactory. However, in practice a young person making a complaint was told at the point when the outcome was being communicated that she could direct an appeal to the principal social worker. In the 2001 inspection report it was recommended that, *"the management committee, in consultation with colleagues form MWHB and SEHB, should continue to explore how to introduce an independent element to the complaints procedure."* The report of the following year made the same recommendation. In this inspection, inspectors found that these recommendations had not been met. They recommend that the management committee fulfil them without further delay.

Practice in relation to complaints regarding matters arising in Gleann Alainn was good, and it is a testament to the staff's responsiveness to the young people that formal complaints were rare. Inspectors are of the view that the policy should be reviewed in order to include the route by which a young person may make an appeal if unhappy with the outcome. The SCU should also develop an inter-board protocol for dealing with complaints or allegations involving young people from referring boards other than the SHB.

Recommendations

18 The unit should develop further its policy and practice guidance for staff in order to ensure that young people are able to exercise their right of access to information.

19 The board should review the unit's policy on complaints to include an independent person to whom young people in the unit can direct complaints, and information about how to appeal against an outcome.

4.4.4 Discipline

Young people whose conduct is unacceptable are dealt with in accordance with positive disciplinary measures approved by the health board.

4.4.4.1 Promoting good order

The unit had a sanctions policy, but in practice there were few sanctions imposed on the young people. The acting unit manager told inspectors that there was no discrete record because sanctions were not generally used. Occasionally, if young people had to pay to replace an item that was broken, they would just do it. There would be no record of their reparation as a sanction. Instead the emphasis was placed on detailed use of life space interviews (based on the TCI model) to identify, explore and discuss behaviour.

The policy referred to removal from group as a sanction. Managers told inspectors that this is no longer used, and that if a young person were misbehaving she would be asked to leave the group, but would not be singly separated. One incident in which a young person was removed form the group concerned her refusal to be searched after returning from an unauthorised absence. Inspectors found searching was subject of a separate policy, and was used sparingly. Staff told inspectors that at the time of the inspection searching was confined to first admissions, and other searches where there was a belief that the young person had a restricted item, if the case management team thought it necessary. Its purpose was to prevent young people bringing into the unit items that might be harmful to themselves or others.

4.4.4.2 Restraint and single separation

The SCU had a policy that the only approved method of restraint was Therapeutic Crisis Intervention (TCI). During the year prior to inspection there had been six occasions when restraint was used. Four young people had been restrained once, and another twice. The unit kept detailed records of the incidents, and had a procedure for notifying the manager, line manager, parents, social workers, and others with a legitimate right to be informed. Solicitors would only be informed if there had been a series of restraints. The board also had a designated person who was sent records of TCI and who assessed its use in all the children's residential centres. Inspectors recommend the inclusion of monitors in this list, as indicated in 4.2.2. above. All the records TCI forms were signed off by the acting unit manager or one of his deputies.

The centre had a written policy on single separation based on the national guidelines on single separation issued by the Department of Health and Children. The acting unit manager told inspectors that single separation was rarely used, and records showed that there had been two instances during the year prior to inspection involving two different young people, one of forty minutes, and the other of one hour and forty minutes. Although there was a room in

which young people could be isolated from the others, it had not been used for some time, and the practice in the unit was to use a suite of rooms separate from the main part of the building. Rather than being confined to one room, the young person who was separated spent time away from peers.

Detailed records were kept of each instance of single separation. They showed that the manager or deputy manager authorised single separation, but they did not show when or to whom the incident was notified, and there was no format for recording observations. Inspectors recommend that the record be altered to include observations and to show the notification routes. As in the case of physical restraint, the monitor should be included in the list of those about single separation in accordance with the recommendation in 4.2.2 above.

Recommendation

20 The managers of the SCU should revise the records for single separation to include details of observation schedules and evidence of the routes of notification of each episode of separation as a significant event.

4.4.4.3 Unauthorised absences

The unit had a written procedure for dealing with unauthorised absences. During the year prior to the inspection there had been 15 unauthorised absences. The shortest were up to two hours, and nine of the absences were overnight. Each was routinely notified to the unit manager, line manager, social worker, Gardai, health board solicitor, and guardian-ad-litem where there was one appointed to the case. Parents were notified, unless the court directed otherwise. It was practice in the unit to keep parents informed when young people remained absent, and there was a procedure for informing all those who had been notified of the absence when the young person returned. Some of the absences consisted of going out of supervision in the vicinity of the unit, but some were away from the unit in the wider community. Generally, practice in relation to the management of unauthorised absences was good.

4.4.5 Safeguarding and child protection

The unit had a written policy on the safety of adults and children which covered some aspects of safeguarding practice. The policy advised staff to have particular sensitivity about physical contact as some of the young people in the unit may have suffered abuse in the past. Staff were also instructed to avoid situations where they were alone with a young person unless visible or audible to a colleague or otherwise able to summon help quickly.

Inspectors found that within the unit staff were aware of several safeguarding practices. They told inspectors that if they had a concern about a colleague's practice they would either bring it up in individual or team supervision, or if it were a more serious concern bring it to the attention of the team co-ordinator or acting unit manager. They knew of the need to ensure that they knocked and were asked in before entering bedrooms, and that they should not be in a bedroom alone with a young person without the knowledge of colleagues who would be nearby. Inspectors were particularly impressed by the understanding of safeguarding issues and practice shown by the Gleann Alainn night staff.

Inspectors found an example of a concern about safeguarding that was brought to the attention of the unit manager and dealt with thoroughly and quickly. As a result of information brought to the staff by one young person a member of staff was subject to disciplinary process for

breach of professional boundaries outside the unit and left her post. The acting unit manager told inspectors that the local child care manager was informed of the procedure, as local child care manager and line manager, and since the young person was placed by another board he informed the child care manager in her home area. Inspectors are of the view this situation was handled well, but advise that where this sort of concern arises it should be notified to the social worker in writing by the unit. The young person's own social worker should have opportunity to assess the situation to determine whether or not there are any child protection concerns, and a record should be kept of that assessment.

Since that incident the SHB developed a draft policy on the professional relationship between staff and young people based on principles of good practice drawn from the Department of Health and Children's guidance: "Our Duty to Care". The policy will apply in all the board's residential centres. It was still subject to consultation at the time of the inspection, but was extremely detailed and specific. It covered the need for confidentiality in relation to all information about the child, and placed confidentiality within the parameters of the staff team rather than one individual. It said that social workers, parents, and other relevant professionals were to be informed when necessary. Inspectors are of the view that there needs to be absolute clarity about informing social workers about information which staff receive from young people, and that the circumstances where it is not necessary should be clearly agreed with the social worker.

The board had also produced a draft policy on safeguarding. It was based on Children First and several guidance documents, including those produced by the SSI. It had a section outlining the need for training of staff in child protection. As shown in 4.2.6 above, the majority of Gleann Alain staff had only the briefing on Children First, and only one had been on the longer training course. Inspectors are of the view that a full programme of training in safeguarding and Children First should be extended to all the Gleann Alainn staff, and that consideration is given to incorporating into it training in understanding, assessing and managing risk.

The SHB had been involved in discussions with the MWHB and the SEHB, and had produced an inter-board protocol for complaints and child protection for Coovagh House SCU in Limerick. The protocol sets out the roles of the boards in situations where there are complaints or abuse allegations that concern young people from different boards' areas, or where allegations are made by a young person after leaving the SCU. It was signed off by senior managers of the three boards. Inspectors are of the view that this should be applied to Gleann Alainn as soon as possible.

The 2001 inspection report recommended that, *"the manager, in consultation with the management committee and staff, should formulate an anti-bullying policy. The policy should treat the issue as a child protection one."* In the following year's inspection the recommendation was repeated. In this inspection, inspectors found that the recommendations had been met, and that an anti-bullying policy was in the policy documentation. It was supplemented by the draft of a recently produced document described as the board's anti-bullying policy. The policy states that all incidents of bullying must be reported, investigated, and acted upon. However, the procedures for dealing with it are internal to Gleann Alainn, and do not reflect the recommendation of the inspectors in 2001 that there may be instances where the issue should be dealt with as a child protection matter. In order to do so, inspectors recommend that board makes a clear distinction between incidents that can be dealt with within the unit and those which need to be referred to social workers. For these more serious incidents the procedures should replicate those of allegations of abuse in that they are referred to the social worker and subject to processes consistent with Children First.

Recommendations

21 In consultation with the MWHB and the SEHB the board should produce an inter-board protocol for Gleann Alainn for dealing with complaints and allegations of abuse.

22 In accordance with the recommendation made by inspectors in 2001, the manager of the unit, in consultation with the management committee and the staff, should further develop the anti-bullying policy to include a distinction between incidents that are dealt with inside the unit and those, where appropriate, which are subject to procedures consistent with the board's implementation of Children First.

4.4.6 Health

All the young people were registered with a female GP associated with the unit. The service provided by the GP was regarded highly by the staff, young people, and parents. She visited the unit or young people went to her clinic whenever it was needed. The night staff told inspectors that the response of the GP at night was a source of reassurance to them. The young people in the centre also had access to all other health services, including dental and ophthalmic, and they received appropriate medical treatment after returning form periods of unauthorised absences. Although managers told inspectors that all young people have medical examinations on admission, records of them could be found neither in the care files, nor in the individual files for each young person that contained information about their health.

The GP told inspectors that she found that the young people in Gleann Alainn had their social, physical and medical needs well looked after by the care staff, and that there was an excellent working relationship with between the staff and the young people. She expressed concern about the difficulties in accessing psychiatric services, particularly for young people from outside the SHB area. She said that she had communicated her concerns to the general manager. The issue of access to psychiatric services is dealt with at length in 4.3.8 above.

4.4.7 Privacy dignity and individuality

Young people told inspectors that their families were respected, and that they were facilitated and encouraged as much as possible in keeping in contact with their families. Those who were not subject to restrictions set by the court were able to make telephone calls in privacy, and while they had to open post in the presence of staff to ensure that it did not contain restricted items, staff did not read their letters. They had individual lockers in the entrance hall where they could keep personal possessions. They used them under supervision of staff, but their importance to the young people was that they were in an area inaccessible to other young people without staff supervision. They felt that they were treated as individuals, and the individual daily outing based around choices they made themselves, reinforced that feeling. Staff are commended for their endeavours to keep to the absolute minimum the controls necessary to ensure the safety of the young people while promoting as normal a day-to-day experience of care as possible, and treating the young people with respect and promoting their individuality.

4.4.8 Aspects of daily living

The daily routine was described to inspectors. The young people were first called at 8.40 a.m. Generally, they were encouraged to have breakfast before the school day, but some ate little.

On days when there was school, classes started at 9.30 a.m. If there was a difficulty because a teacher had not arrived the young people were allowed to spend time in quiet activity, but the television was not turned on. On days when there were lessons there was a short break at 11.00 a.m. and an hour's break for lunch at 1.00 p.m. The afternoon classes were from 2.00 p.m. to 3.00 or 3.30 p.m. During the day there were five staff on duty. On school days two supported the teachers. Others prepared lunch. Between 3.30 and 6.30 there was a staff young person ratio of one to one, which facilitated each young person having an outing for one hour. Dinner took place from 6.30 to 7.30 p.m. After dinner there were in-house activities. Night staff came on duty at 9.00 p.m. They carried out checks on the bedrooms for any objects that might be unsafe, and the young people had to stay in their rooms after the checks had been carried out. The time for the settling process was up to two hours. Staff went off shift at 11.00 p.m. The two waking night staff were supported by two sleep-in staff. While young people were in their rooms after the checks, the staff spent time talking to individual young people and reassuring them before they settled to sleep. The bedroom doors were not locked, but they were fitted with sensors so that night staff could react to any movement outside the room. Discrete checks were carried out by night staff every 20 minutes. Inspectors advise the board to consider the intrusiveness of such frequent checks, and suggest that consideration be given to determining their frequency by the use of risk assessments and a risk management action plans. The staff told inspectors that although the process of settling the young people took time, disturbances at night were not common.

4.4.9 Personal appearance

Young people went shopping with staff for clothing and other items for themselves. The staff carried the cash, and handed it over to the young people when it was required, and the young people were clear that they had to account for how they used it. They received 14 euro a week pocket money. There was a rule that a young person could not carry more than seven euro at any given time. The young people believed that the allowance for clothing was adequate. They were able to purchase their own clothing from shops of their choice. Toiletries were bought with the unit's shopping and kept in a store room. Young people could ask for them as they required them.

4.4.10 Leisure activities

A general pattern of outings from the unit was risk assessed at the pre-placement meeting for each young person. Once a week each young person had her own evening for individual activities. Staff found that they were better enjoyed by young people when they were on their own. The young people told inspectors that after admission there was usually a period of two weeks before they could go on outings, but after that they were able increase the number of outings according to their behaviour. Young people could choose an activity. They enjoyed swimming, horse-riding, and cinema, but the favourite activity was shopping. The young people regarded the opportunity to go on outings as an important facility. It was a key factor in the management of behaviour, and withdrawal of an outing is seen as a serious sanction.

4.5 Premises, safety and security

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 that is, in so far as practicable, appropriate to its designation as a children's home. It must also be properly maintained and furnished.

4.5.1 Risk Assessment

The unit had a risk assessment procedure referred to in 4.2.6 and in greater detail in 4.4.5 above. It is a formal system supported by a simple, accessible recording instrument. The team co-ordinators and staff told inspectors that they found it a useful means of formalising their day-to-day judgements about risk. There were also procedures and practices that supported staff in managing risk. They included: personal alarms for staff to carry when on duty in the unit, sensors on the young people's bedroom doors, and regular checks in bedrooms and other areas to ensure that items that might be used for self-harm were not present. A CCTV system was in place to ensure the protection of the young people by monitoring movements of people outside the unit. Fittings in the units were designed to be durable and fixed so that the risk of their being used by a young person to harm herself or others was minimised.

4.5.2 Location and design

The unit was in a single storey building converted for use as a special care unit. It was situated on a campus of buildings belonging to the health board. Within the constraints of safety and security it had some domestic features.

4.5.3 Accommodation – general

Inspectors carried out an inspection of the building. The exterior was in good condition. The overall impression of the interior was that there were areas which required attention. The general décor of the common areas of the unit was consistent with average wear and tear. However, staff told inspectors that it was difficult to keep the building clean and tidy, with six teenagers in residence, in the absence of a housekeeper. Staff said that there had been advertising campaigns to get a cleaner for the unit, but none had received a response.

On inspection of the unit inspectors found several areas of the unit where small repairs were needed. In the kitchen there was a cooker in need of replacement and a fridge in need of repair or replacement.

Managers are urged to introduce as soon as possible a system to ensure that high standards are set and maintained in the upkeep of the unit.

Recommendation

23 The managers of the unit should arrange for the unit to be cleaned regularly and for the replacement or repair of damaged kitchen equipment.

4.5.4 Accommodation for individual young people

Inspectors found that the individual bedrooms were spartan in quality. Some did not show evidence of personalisation. The furnishings were fixed in order to prevent young people from using them to harm themselves or others. Several of the young people interviewed by inspectors complained about the lack of ventilation in the bedrooms. This was particularly noticeable for them during the hot weather over the summer. Inspectors urge managers to address this issue as soon as possible.

Recommendation

24 The managers of the unit should address the issue of ventilation in the young people's bedrooms as soon as possible.

4.5.5 Maintenance and repairs

Some of the observations of the unit by inspectors were of uncompleted maintenance work. Managers told inspectors that maintenance was based in the local hospital. Responses to requests varied, and the delays were not always explained. Some of the outstanding work was left unfinished by the board's building team. This included small finishing jobs like painting a replacement door surround. Inspectors found that the unit did not have a clear record of requests for repairs identifying which related health and safety risks and which were routine. There was no system for tracking the speed of response. Inspectors recommend that all managers arrange for all outstanding matters to be dealt with as soon as possible, and that a clear, accountable system of logging requests and completion of repairs is introduced.

Recommendations

25 The board should ensure that the requests for repairs of the unit are responded to quickly.

26 The managers of the unit should introduce a system for recording and following up requests for repairs and maintenance, identifying clearly those that refer to health and safety concerns.

4.5.6 Safety and fire precautions

The centre did not have a recent health and safety audit. Inspectors were shown a written communication from the board's fire and safety officer stating that under the SHB's safety statement it is the responsibility of manager of a centre to conduct the audit. The communication said that a detailed outline health and safety audit/inspection checklist, prepared in May 2003, was made available to assist managers in this process.

The acting unit manager told inspectors that this represented a departure from previous practice where safety officers of the board had been to the unit to carry out assessments. The checklist shown to inspectors had details of assessments that would have required some technical knowledge on the part of managers, and no training had been provided to enable them to carry out this role.

Inspectors are of the view that this change in practice needs to be discussed fully by all parties involved, and that managers are clear about the scope of what they can assess. In the inspection of the unit inspectors found several places where there were potential ligature points. In the discussions the potential risk of self-harm by young people referred to a special care unit should be given due consideration.

Recommendation

27 The general manager should determine exactly how health and safety checks in the SCU are to be conducted.

The unit had written confirmation that fire alarm and fire fighting equipment had been recently checked. The unit also had a recent fire certificate. The new health and safety representative for the unit had ensured that fire drills had taken place, and had introduced evacuation drills in January 2003. The fire alarm system and fire extinguishers were checked once a week by night staff.

Inspectors found that smoke detectors and extinguishers had been checked regularly, and that the last check had been carried out in December 2002. Twelve of the 14 fire extinguishers seen by inspectors had dates indicating that they had also been checked in December 2002.

The unit manager told inspectors that all staff were aware of the procedures regarding medication, and that the decision on how medication should be administered was made by the board of management. It involved preparation of weekly blister packs by a pharmacist. Over the counter medicines were covered by the same procedure as prescribed medicines. They were locked in a cupboard in the staff office, and a record was kept of their administration. Staff were permitted to use the over the counter medication for their own purposes, but did not make a record of when they did. Inspectors found that in spite of the provision to keep medication locked up a large quantity of it was in blister packs on top of the filing cabinet in the staff office. Staff explained that it was prescribed medication from courses that had not been completed awaiting return to the pharmacist. Inspectors recommend that the unit managers review practice in relation to the administration of medication to ensure that such errors cannot happen again.

As part of their medical examination for employment, all permanent staff had vaccinations against Hepatitis B. Up to the time of the inspection temporary staff were not required to have a medical examination as a condition of their employment. However, managers informed inspectors that this practice was due to change, and that all staff would have medicals. Until that point vaccinations for Hepatitis B was offered to temporary staff, but they could choose to opt for them.

Smoking by young people was not facilitated. Some of the young people smoked outside the unit, but following a court direction in one case, the unit had a policy of not sanctioning young people for smoking. Managers told inspectors that there was a programme of health promotion which included encouragement to give up smoking. Inspectors were concerned to find cigarette butts strewn around the back door of the unit where staff smoked. Staff are urged to reconsider this practice, and to keep in mind the message their own approach to smoking gives to the young people in their care.

The unit had a health and safety statement dated from 1999. It will require updating in order to reflect the change of management of the unit, and any changes in how the responsibilities for safety are determined by the board.

4.5.7 Security

The structure of the unit had safety features, such as ‘bank’ glass in the windows. Inspectors were told that the glass shatters rather then breaks. The glass panels in the bedrooms were of the same quality. The manager told inspectors that all bedding and furniture in the unit was fire resistant. There was a visitors' book which recorded the names and length of visit of each visitor to the unit. Other security features are referred to in 4.5.1 above.

4.5.8 Insurance

Inspectors were shown written evidence that the unit was covered by the health board's insurance policies for the year 2003. They are due to be renewed on 1st January 2004.

4.6. Education

Education should be seen as an integral part of the care of the young person. The education of all young people 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, young people over the age of sixteen should be offered a programme of vocational preparation, training and work experience or transition to further education.

Inspectors found that the young people in Gleann Alainn were not receiving full time education. In 2000 inspectors found that education was provided within the unit. In 2001 an educational facility was opened in another building on the same campus as the SCU. It was intended that the school would provide education for up to 22 young people from the SCU, two local HSUs and a children's centre. The school was under the aegis of the VEC. It ran into difficulties regarding staffing, and at the time of this inspection was without a principal.

The former principal of the educational facility expressed concern to inspectors that some of the young people were admitted to the unit without adequate reports about their educational background or assessments. Although the care staff were supportive of the young people in ensuring that they attended classes when they occurred and facilitating access to external training, the absence of a full time educational service limited the scope of their support.

The result of these problems for young people of school age in Gleann Alainn was that they did not have access to a full curriculum, and the standard for meeting their educational needs was not met. The unit had a classroom and gymnasium in which education could be delivered. Managers of the unit estimated that after the establishment of Ard Alainn education provision to the young people in Gleann Alainn had been reduced to about a third of what it had been. They also said that owing to the use of teachers on a sessional basis it was often difficult to find out what the daily timetable would be. On the first day of the inspection staff in the SCU did not know what was due to happen even though the start of the new term was the following day.

One young person of school age was attending a centre in Cork to access a FAS training course. For another 17 year old and the two other young people of school age the daily programme required them to attend education in the classroom in the SCU from 9.30 a.m. to 3.30 p.m. with morning and lunch breaks. They received a full day's education only on days when teachers arrived at the unit to provide it, but there was no fixed timetable, and often there were not enough teaching hours covered to ensure that they had a full day in the classroom. The 17 year old young person in transition between the SCU and high support unit was attending Ard Alainn five days a week from September 2003 in order to gain her applied leaving certificate. She was accompanied to the educational facility by the HSU staff that were looking after her in the SCU, and they assessed the situation and decided on a daily basis whether or not they should stay in the classroom to offer support. Staff said that this degree of trust and flexibility was possible because she herself was focussed and motivated.
Her mother also praised staff of Ard Alainn for supporting her daughter in her education, and improving her overall confidence. She felt that she was involved in the process, and said that copies of all school reports were posted to her.

Staff in the SCU told inspectors that generally the young people had positive attitudes to their education, but it was difficult for staff to encourage them when the timetable varied from day to day. Some of the planned lessons were postponed or cancelled, and staff were aware of some lessons when a teacher turned up at the unit. The managers and staff of the SCU said that while they were concerned about the inadequacy of the educational provision for the young people they did not feel that they were able to change the circumstances which brought them about.

The general manager and the child care manager gave details to inspectors of the measures they have taken to endeavour to meet this standard, including referring the difficulties to the Department of Education and Science, and advising the Special Residential Services Board and the Department of Health and Children of the issue.

The provision of education to young people in the unit did not meet the standard, and there is an urgent need to ensure that the young people receive the full education they are entitled to as soon as possible. There is also a need for the management committee and the admissions and discharges committee to insist that the documents outlining the educational history and any educational assessments of the young person referred are provided by the referring social workers. These are essential if the young person is to have any continuity of education as she moves from one place to another within residential care provision. They are important also because with the implementation of the Children Act 2001 and the consequent shorter periods of detention there will not be the same time as at present to carry out assessments in the educational facility and follow it through with a comprehensive programme of education, unless the young person is from the SHB area and moves to the local step-down unit.

While acknowledging that the SHB has already taken steps to address the difficulties, inspectors recommend that the managers of the board give the resolution of the problems in providing full time education to the young people in the unit the highest possible priority.

Recommendation

28 The managers of the SHB should give the highest possible priority to resolving the problems in providing full time education to the young people in the SCU.

5. Summary of Recommendations

1 On the implementation of the Children Act 2001 and the introduction of special care orders, the board should revise the statement of purpose and function to reflect the new legal requirements that will be in place.

2 The board should ensure that all outstanding Garda checks and written references for current staff at Gleann Alainn and the HSU are sought.

3 The board should review its system of recruitment and vetting to ensure that the Department of Health and Children's guidelines for vetting staff before employment are followed in all future appointments of staff in children's centres.

4 The board should introduce regular monitoring of the vetting system in order to be assured that it provides the safeguards for which it was established.

5 The board should ensure that all staff in Gleann Alainn be trained in TCI, safeguarding and Children First.

6 The board should increase the number of staff trained in first aid, and provide training on risk assessment and risk management, fire safety, and health and safety.

7 In accordance with the recommendation made in the 2000 inspection, the managers of the unit should audit the training needs of Gleann Alainn staff, and produce a training action plan.

8 As a matter of priority, the board should review the options available to meet the need of the SCU for regular step down placements.

9 As a matter of the highest priority, the managers of the MWHB, SHB and SEHB should develop a common protocol to ensure that each young person placed in Gleann Alainn has a completed care plan at the time of admission.

10 The social workers of young people currently in the SCU without care plans should ensure that plans are prepared and copies given to the unit, the young people and parents as soon as possible.

11 The managers of the board and monitors of residential centres should introduce a system of regular checks to ensure that care plans and care plan reviews conform to the requirements of the regulations and standards.

12 Principal social workers in the referring boards should ensure that supervising social workers read care records in the unit from time to time in accordance with the regulations and standards.

13 In line with recommendations made in 2001 and 2002, inspectors recommend that the managers of the MWHB, SEHB and SHB give the resolution of the problems in providing a psychiatric service to the young people in Gleann Alainn the most urgent attention.

14 In accordance with the recommendations of the 2000 inspection report, the board

should ensure that all files are harmonised with those of social workers, and contain all the documentation required by the regulations.

15 The acting centre manager should review the SCU's system of individual care records and produce detailed practice guidance for staff on the production and maintenance of them.

16 Managers and monitors should carry out regular checks of the recording system in the SCU to ensure that they are of an acceptable standard.

17 The unit managers and staff should develop further the policy and practice on religion.

18 The unit should develop further its policy and practice guidance for staff in order to ensure that young people are able to exercise their right of access to information.

19 The board should review the unit's policy on complaints to include an independent person to whom young people in the unit can direct complaints, and information about how to appeal against an outcome.

20 The managers of the SCU should revise the records for single separation to include details of observation schedules and evidence of the routes of notification of each episode of separation as a significant event.

21 In consultation with the MWHB and the SEHB the board should produce an inter-board protocol for Gleann Alainn for dealing with complaints and allegations of abuse.

22 In accordance with the recommendation made by inspectors in 2001, the manager of the unit, in consultation with the management committee and the staff, should further develop the anti-bullying policy to include a distinction between incidents that are dealt with inside the unit and those, where appropriate, which are subject to procedures consistent with the board's implementation of Children First.

23 The managers of the unit should arrange for the unit to be cleaned regularly and for the replacement or repair of damaged kitchen equipment.

24 The managers of the unit should address the issue of ventilation in the young people's bedrooms as soon as possible.

25 The board should ensure that the requests for repairs of the unit are responded to quickly.

26 The managers of the unit should introduce a system for recording and following up requests for repairs and maintenance, identifying clearly those that refer to health and safety concerns.

27 The management committee should determine exactly how health and safety checks in the SCU are to be conducted.

28 The managers of the SHB should give the highest possible priority to resolving the problems in providing full time education to the young people in the SCU.