Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Gleann Alainn Special Care Unit in the Health Service Executive South

Inspection report ID number: 589

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About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which has been established to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services — Developing person centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

Social Services Inspectorate — Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services. Monitoring day and pre-school facilities[1]

Monitoring Healthcare Quality — Monitoring standards of quality and safety in our health services and investigating as necessary serious concerns about the health and welfare of service users

Health Technology Assessment — Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

Health Information — Advising on the collection and sharing of information across the services, evaluating information and publishing information about the delivery and performance of Ireland's health and social care services

[1] Not all parts of the relevant legislation, the Health Act 2007, have yet been commenced.

Contents

1. Introduction

The Health Information and Quality Authority's (the Authority) Social Services Inspectorate (SSI) carried out a full inspection of Gleann Alainn Special Care Unit (SCU) in the Health Service Executive South (HSE South), under Section 69(2) of the Child Care Act, 1991. This was an announced inspection that took place between 5 and 7 October 2010. This is the report of the findings of that inspection.

SCUs are inspected annually against the Child Care (Special Care) Regulations 2004[2] and the *National Standards for Special Care* (2001, see Appendix 1)[3]. The last full inspection took place in October 2009 and can be accessed on www.hiqa.ie as report ID number 349. The follow-up inspection to this took place in April 2010 as ID number 387.

Gleann Alainn is managed by the North Lee Local Health Area of the HSE South and is a national resource for all HSE local health areas since January 2007. Prior to this the Unit provided places to girls for the HSE South region only. It offers secure residential care for up to five girls aged between 11 and 17 years inclusively. Children are detained in a special care unit under a High Court detention order on the basis that they pose a serious risk to themselves or others. Under High Court order, the children's liberty is restricted in order to secure their safety and welfare needs. There are three such units in Ireland, where children can be placed by a National Special Care Admission and Discharge Committee which considers referrals from all 32 local health areas in the HSE.

At the time of the inspection, there were four girls detained in the Gleann Alainn Unit. Two other children had moved to their onward placement since the announcement of the fieldwork in September 2010.

The Unit is located in the grounds of a hospital. It is a single-storey building surrounded by a large wooded area and green fields. There was a large secure open area to the rear of the building.

Inspectors found that the majority of Standards were met in the Unit. Inspectors found that children were well cared for and that the child-centred culture and ethos of this service was very much in evidence. There were also key areas for improvements. There were no areas where practice did not meet the required standard. However, inspectors had serious concerns about the sustainability of the management arrangements and requested an immediate response from the HSE South North Lee Local Health Area Child Care Manager and North Lee Local Health Area General Manager to address the temporary management arrangement that had been in place since August 2010. The HSE South North Lee Local Health Area Child Care Manager responded appropriately and a temporary deputy manager was put in place shortly after the inspection pending a longer term solution.

[2] S.I. 550/2004
[3] www.hiqa.ie/functions_ssi_child_standards.asp

1.1 Methodology

In this inspection, inspector's judgments are based on evidence of findings verified from several sources. They are gathered through direct observation of the interactions between staff and children, interviews with Unit staff, relevant HSE personnel and managers, the monitoring officer and interviews with four children, examination of relevant records and documentation detailed below and an inspection of the accommodation.

Inspectors had access to the following documents:

- the Unit's statement of purpose and function, policies and procedures
- the Unit's register
- the children's care plans and care files
- information on staff
- information on children
- administrative records
- staff rosters
- staff supervision and training records
- fire safety compliance documents
- evidence of insurance
- details of unauthorised absences for previous 12 months (11)
- details of physical interventions for the previous 12 months (12)
- details of single separation[±] for the previous 12 months (5)
- monitoring reports.

1.2 Management Structure

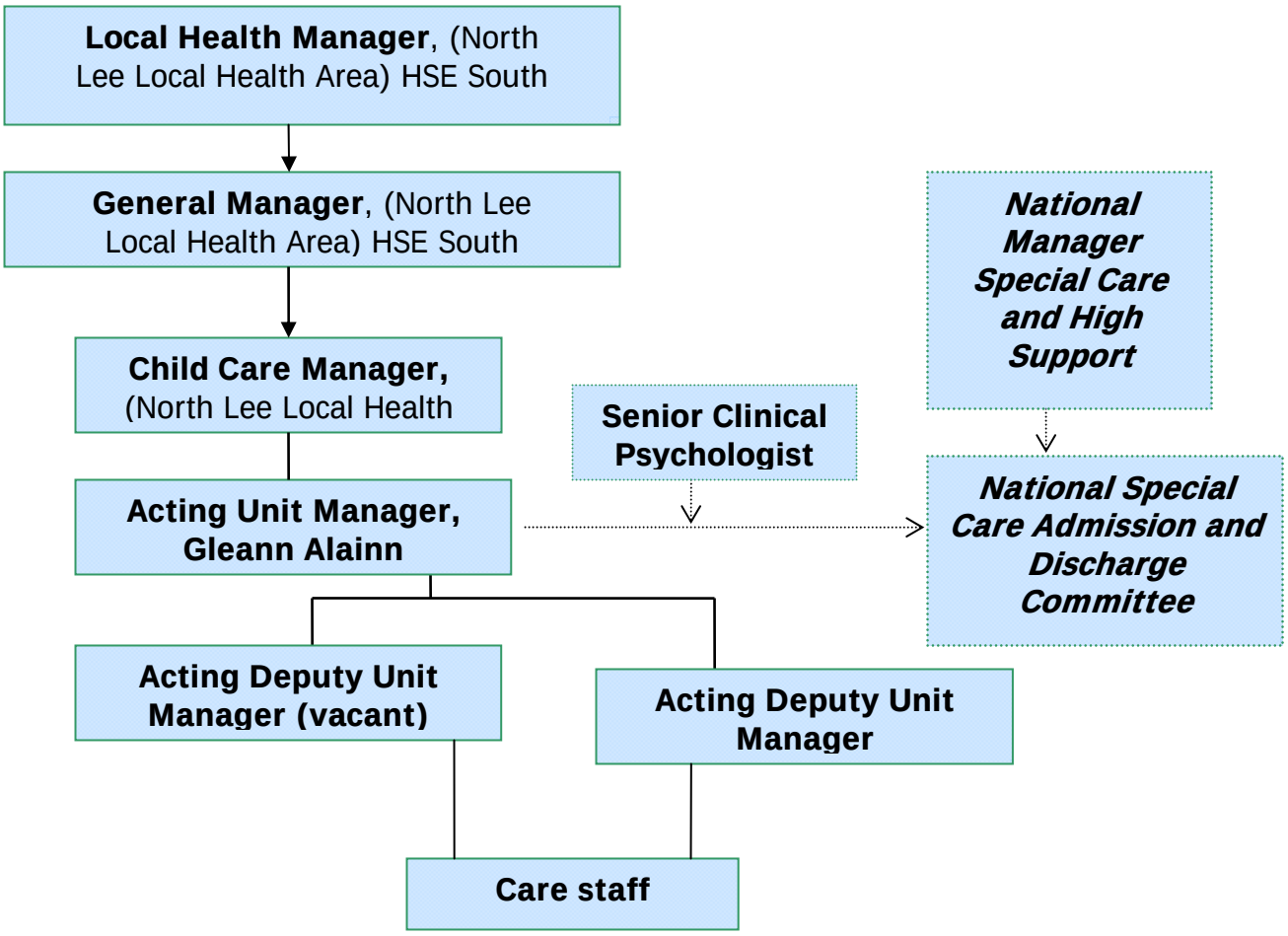
At the time of the inspection, one of the Deputy Managers was acting up into the role of manager. The previous manager had transferred in early August 2010 to manage another SCU. The second Deputy Manager was on sick leave from the Unit since early August 2010. The Acting Unit Manager reported to the Child Care Manager of the North Lee Local Health Area in the HSE South, who in turn reported to the General Manager. The management of the Unit was in the process of being transferred to the National Manager Special Care and High Support.

The National Manager Special Care and High Support had an oversight of all SCUs nationally and line managed the two other SCUs in the country. There was a National Special Care Admission and Discharge Committee and weekly meetings with all SCU managers.

The management structure of Gleann Alainn is shown in Chart 1 below.

[±] Single separation is defined as the isolation of a seriously disruptive young person, for as short a period as possible, to give him/her an opportunity to regain self-control. Source: *National Guidelines on the use of Single Separation in Special Care Unit* (2003)

Chart 1. Management structure of Gleann Alainn SCU – October 2010



1.3 Data on children

Inspectors examined the Unit's register and found that in the 12 months since the last inspection there had been 11 children in Gleann Alainn. The Unit has been at full capacity the majority of the time. One child, not resident at the time of inspection fieldwork, had been admitted twice in 2010. Details of the children present in the Unit at the time of the inspection are given in Table 1 on the next page. For one child this was their fifth special care placement in three years.

Table1. Children present in Gleann Alainn at the time of the inspection

Child	*Male/Female*	*Age*	*HSE Area which placed the child*	*Length of placement*	*Number of previous placements*
# 1*	F	15	Dublin North East	5 months	Foster care (1) Residential (2) Special care (1)
# 2*	F	16	Dublin Mid-Leinster	7 months	Residential (1)
# 3	F	16	South	5 months	Special care (4) Foster care placements (3)
# 4	F	15	Dublin Mid-Leinster	5 months	Residential (5)
# 5	F	16	Dublin North East	1 month	Awaiting information from social worker
# 6	F	15	South	1 day	Residential (2) Foster care (2)

**Please note child 1 and child 2 had moved to their onward placement at the time of the inspection fieldwork.*

Please note that one child arrived into Gleann Alainn on the day of the inspection. She met with inspectors but her social history and other information was not available.

1.4 Acknowledgements

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

2. Findings

2.1 Practices that met the required standard

Primary Care/ aspects of daily living
Inspectors found that the children were well cared for and respected in the Unit. Children in special care are generally placed there on an involuntary basis and do not wish to be there. The skill of the staff team in working with these children and developing positive relationships was commendable. Inspectors were told that the focus on building relationships and positive attachments was the core part of the model of care in promoting changes in the children's behaviour. The children spoke highly about the staff and told inspectors that they felt cared for and safe. Inspectors observed positive interactions and activities such as baking and shared meals by the staff and children. The children's individual interests were actively encouraged and the educational unit also worked closely with the children in developing their skills and aptitudes. The primary care of the children was well met.

Monitoring
This standard was met. The HSE Monitoring Officer visited on a monthly basis and had written regular reports on his findings. He was notified of significant events.

Consultation with children and complaints
The Standards on consulting with children and complaints were good. The children and staff members were familiar with the complaints procedure and identified staff or external people they could talk to. They were confident that staff members and the Acting Unit Manager would listen and respond to their concerns.

Family contact
There was evidence from interviews and Unit records that there was regular contact with families where appropriate. Several of the children spoke to inspectors about missing their families and friends. As several of the children were from throughout the country staff members spent considerable time travelling with them to facilitate contact with their families. While this was commendable, it had a significant impact on staff resources. Inspectors found that in four weeks there were 21 trips across the country for three children. Two staff members accompanied these children. This issue is further discussed under the standard of 'Purpose and Function'.

Register
The Unit maintained a register on the children which contained the required information under the regulations.

Single separation
The practice of single separation was used infrequently. There were five incidents of single separation involving four children in the previous 12 months. These incidents were managed appropriately, recorded, monitored and notified to the relevant persons.

Unauthorised absences

There had been 11 unauthorised absences involving seven children since the last inspection. All absences were reported to the appropriate people including Garda Síochána, parents, social workers, guardians ad litem, and the HSE monitoring officer. However, two children went missing together for seven days in July 2010. This was a matter of concern and all relevant persons were informed. The children involved have not been absent since.

Use of physical restraint

Physical interventions were used infrequently with the children. In the previous 12 months there had been 12 incidents of physical restraint/intervention involving four children. These incidents were notified to relevant HSE personnel and reviewed by the HSE Monitoring Officer. All staff members had been trained in the therapeutic crisis intervention (TCI) model of behaviour management. The Unit also had a personal alarm system for each staff. The HSE TCI coordinator external to the Unit had not received notification of interventions. This should occur as an additional safeguard for children.

Legal and court work

Each child had a copy of the High Court order on file. The children had court appointed guardians ad litem. They had frequent contact with the children and attended review meetings. Children spoke positively about their guardians ad litem. Some of the children had also attended these court proceedings. Some external professionals highlighted the need for children to be well prepared for these court visits including what to expect.

Security

Inspectors noted there was adequate security in the Unit including installation of a new system of locks and a closed circuit television (CCTV) system. Inspectors during the fieldwork had to sign in and out a set of numbered keys.

Premises

The Unit was well maintained. The décor was suitable with good ventilation and natural light. There was a large external area for outside activities. There was a well lit kitchen and considerable resources had been invested to provide good quality accommodation.

Safety and fire precautions

The Unit had an up-to-date health and safety statement and an audit had been carried out by the HSE fire officer in October 2010. Fire training was also completed in October 2010. This highlighted the need for first-aid training for staff as a matter of priority. This is discussed under ‘Training and Development’. Medicines were stored in a secure cabinet in an inner locked room off the staff room. The medication administration book was signed by two people each time medication was given to a child.

2.2 Practices that partly met the required standard

Management
The standard on management was met in part. The Acting Unit Manager was appropriately qualified and the staff team and children spoke highly of her. The Manager provided good leadership in maintaining the child-centred culture of the service.

Overall, inspectors had serious concerns about the governance of this service. Specifically inspectors highlighted the impact of the transition process in transferring governance from local to national management on care practices in the service.

The HSE national strategy for special care and high support was that these services would be line managed at a national level. This transition process took place during the past year, and two of the three Special Care Units were now under a national management structure. At the time of inspection fieldwork, Gleann Alainn remained under local management and the transition process was ongoing. During interviews, inspectors found a degree of frustration and anger about this transition process from local management. Poor communication and a lack of clear direction about the future model of the service contributed to significant levels of concern among the staff team and management.

For example, Gleann Alainn had until recently one unit manager and two deputy managers. In August 2010, the Unit Manager with another staff member were moved to another special care unit. Inspectors were told by the HSE South line management that the understanding was that this was a temporary arrangement for a two-week period. This arrangement was still in place at the time of the inspection seven weeks later. Since this time one of the Deputy Managers acted up into the role of unit manager. At the time of the inspection the second Deputy Manager was on sick leave.

At the time of the inspection, the Acting Unit Manager was either on site or on call for the Unit without a break for seven weeks. Inspectors could not establish a timeframe, from either the line manager or the National Manager Special Care and High Support for when this would be resolved. This was unacceptable. The current arrangement was unsustainable and inspectors requested the HSE to resolve the management issues without delay.

Inspectors noted that the impact of the lack of robust management structure and clear leadership as follows:

- staff members had not been supervised
- increase in levels of sick leave by staff members in 2010 (619 days by 28 staff members)
- case management systems to guide work with children had fallen into abeyance
- draft therapeutic model of care had not been agreed and implemented
- shift coordinators had not been assigned as identified in the last inspection
- evidence of inconsistent practices by staff team members

- dissatisfaction from some external professionals about communication and the lack of therapeutic interventions with children.

These matters need to be addressed in order to maintain and build on the strengths in this service and prevent further deterioration in the care provided to the children.

Inspectors recommend that the HSE should:

1. Immediately stabilise the management of the Unit to ensure it is sustainable and the Acting Manager adequately supported.

2. Resolve the current management issue and put in place a long-term management solution.

3. Ensure that the change management process from regional HSE management to national HSE management is well managed through good communication and sharing of information with local management and staff members.

4. Ensure that specialist human resource support is provided to management.

The ability of management to address employee issues was also a concern. One allegation made against a staff member – that was subsequently unfounded – took over 12 months to resolve. Inspectors noted there also was a lack of clarity in addressing practice issues with staff members through a robust supervision process. The HSE should provide specialist human resource support to support the management in addressing areas of concern.

Inspectors recommend that the HSE should:

5. Ensure that all staff members receive supervision as a matter of urgency.

Staffing

At the time of inspection, the Unit had a total of 25.5 approved whole-time equivalent posts filled by:

- a unit manager
- two deputy managers
- 23.5 child care leaders
- one administrator.

At the time of the inspection, there were six relief child care workers providing full-time cover. The Acting Unit Manager told inspectors that the Unit was short staff due to sick leave and maternity leave. Agency staff members were used on a regular basis to address shortfalls in staffing levels. Staff members also spent considerable periods of time travelling with children

around the country to meet family members and attend court. This reliance on temporary staff members was a serious concern and the impact on the model of care is further discussed under 'Emotional and Specialist Support'.

Six of the child care leaders did not have any qualification. This was a concern and should be addressed in a supportive manner by line management. There was also inadequate training of staff members and this will be discussed under 'Training and Development'.

The staff roster did not facilitate team meetings. On inspection of team meeting minute's inspectors found that attendance was poor with only six or seven staff members attending at a time. This issue was previously raised in the last inspection and had not been addressed.

Purpose and function

The last inspection highlighted the need for the purpose and function and policies of this service to be updated. This had not occurred. Inspectors were provided with policies and procedures dated from 2002. Inspectors noted that aspects of the model of care outlined in the document were not reflective in practice. This included a case management team to provide leadership and guidance in the interventions with the children. The purpose and function was out of date and did not reflect key changes in the role of the Unit in the provision of special care nationally. Inspectors found that the service was in a developmental vacuum pending its transition into the national structure. Endorsing a new model of therapeutic care, recruiting a new psychologist and developing the new purpose and function and new polices were pending this transfer.

Due consideration should be given to working with the families of children in special care. The staff team in Gleann Alainn spent a considerable amount of time travelling with children to their families. The HSE should consider the pivotal role that families often have in a child's life and how this work could be developed in a special care model and included in the purpose and function.

Inspectors recommend that the HSE should:

6. Ensure that the statement of purpose and function is reviewed to define its role within the national child care service including the therapeutic model of care.

7. Ensure that the purpose and function should reflect how the Special Care Unit will work with families.

Emotional and specialist support

Children in special care are there for a limited period of time. The decision to place them in special care where their liberty is strictly limited can only be granted by the High Court and is a serious and significant action. For this reason there are multiple safeguards in place including a rigorous admission process, appointment of guardians ad litem and the judgment of a court to

grant such detention orders. The purpose of special care is to provide a place of containment for a child to restrict their ability to engage in unsafe and oftentimes dangerous behaviour and address these behaviours through targeted interventions.

The standard on emotional and specialist support was met in part. The Unit had the services of a dedicated principal clinical psychologist. He attended staff meetings and supported key workers. He undertook direct work with some of the children. While children from the Local Health Area could access support from the local HSE psychiatric service this was not available for children from outside of the Local Health Area. Children were referred to external agencies to address specific areas of concern such as sexual relationships, addiction and other issues. The staff team themselves under took a positive role-modelling approach with children. Assisting the children in having positive adult attachments and building their self-esteem was reflected in the work of the Unit and in the educational unit. However, while inspectors found that building positive relationships was the cornerstone of this service, further improvement in this area was required.

Inspectors were told that the case management system which guided the direct work with the children was no longer in use. This was a direct consequence of the recent changes in management as the former manager and Deputy Managers had a key role in guiding this work. The current clinical psychologist was retiring in the coming months and there was no definite plan on how his role would be replaced.

The pending departure of the psychologist, the lack of access to psychiatric interventions for children outside of the area and the lack of the case management system had a direct impact on the therapeutic work of the service. This lack of intervention was highlighted as a serious matter of concern by external professionals.

It was unacceptable that there was not a rigorous process of assessment, case formulation and targeted interventions aimed at reducing the unsafe behaviours that necessitated these children being detained. Inspectors recommend that the HSE should agree on the therapeutic model of care and a framework for its implementation in accordance with best practice. The Unit should also link in with external therapeutic services involved with the children to guide their work in the Unit. There should also be a system to assess the effectiveness of the model in addressing the unsafe behaviour presented by the children.

Inspectors recommend that the HSE should:

8. Ensure that children receive adequate emotional and specialist support to address their unsafe behaviour which necessitated their placement in special care.

Promoting positive behaviour

There was evidence that the staff team focused on their positive relationships with the children in managing challenging behaviour. There were a low number of restraints, single separations and unauthorised absences. Each child had an individual crisis management plan (ICMP) that identified triggers for each child and the best ways to manage a child when they begin to get angry and aggressive. This was commendable.

There were key areas requiring improvement. The roster was made up of three teams of staff that worked shifts together. Both staff members and children identified inconsistencies in practices across these teams. Therefore, what one staff team permitted on one evening may not be permitted by a different team on the next evening. This was unfair on the children and could result in serious incidents due to frustration and a sense of unfairness. It was also unfair on staff members implementing the agreed rules and had created conflict between teams. Inspectors were told that some staff members were reluctant to challenge the children and therefore these inconsistencies occurred.

Grounding was one of the most common sanctions. This meant that a child would be confined to the Unit for 24 hours with no activities external to the Unit. Inspectors noted that this sanction was used indiscriminately in response to significantly different types of aggressive behaviour ranging from verbal abuse of staff to actual physical assaults. Also, if a child was addicted to nicotine and smoked cigarettes, they were doubly sanctioned when grounded as smoking generally occurred outside the Unit on outings. The staff team were proactive in encouraging children to stop smoking in accordance with HSE national policy. Inspectors were told that at times agreed sanctions by one team were not implemented by the second team coming on duty.

Inconsistencies across the teams, combined with the lack of targeted interventions outlined earlier, was a serious concern and significantly undermined the work of the Unit in addressing the high risk behaviour of the children.

The high number of agency staff members, the lack of a resilient management structure, the lack of a shift coordinator, poorly attended staff meetings all contributed to inconsistent practice and poor communication. These factors should be addressed immediately by the National Special Care and High Support Management Team and HSE South.

Inspectors recommend that the HSE should:

9. Ensure that the post of shift coordinator is established without further delay.

10. Ensure that the roster and deployment of staff are reviewed so as to facilitate full staff meetings and a training programme.

11. Address inconsistencies in practices between teams in the Unit through improved communication and increased accountability in care practices.

Considering the weakness in the current service it is commendable that the staff team members continued to provide a strong ethos of care and nurturing to the children.

Notification of significant events

This standard was met in part. The Unit had implemented the national policy for the notification of significant events and records of these notifications were maintained. Some professionals highlighted delays in receiving notifications and records about significant events.

Referral and placement of children

All referrals to special care units come through the High Court after an application to the National Special Care Admission and Discharge Committee. The Acting Unit Manager sits on this committee. This committee facilitates the sharing of information with the managers for new children being placed in this service. Inspectors were told that this generally works well. However, staff members had very little information on one child that arrived on the first day of inspection. This was a planned admission. As the Acting Manager had not attended the national admissions meetings due to constraints on time, the information provided for the admission was not available. This needs to be addressed for risk management and so that staff members have all the necessary information on a child prior to admission.

Inspectors found that one child was in their fifth special care placement. Another child had two placements in Gleann Alainn in 2010. The National Manager should implement a system for special reviews of a child's care and placement history when they have been referred to the admissions panel for another placement in special care in a short period of time. The purpose of such reviews is a learning exercise and to prevent further placement breakdowns and admissions into special care.

Inspectors recommend that the HSE should:

12. Ensure that adequate information is provided about each child on their admission.

13. Ensure that there is a case management review process for children who have two or more placements in special care in a short period of time.

Administrative and care files

Overall, the recording systems that operated in the Unit were of a good quality. However, there was inadequate information on file for one new arrival and statutory care plans were not available for all children.

Training and development

This standard was met in part. The majority of staff members were trained in TCI. None of the staff members had up-to-date first-aid training. Considering the levels of risk including children

that may self-harm or have addictions this should be addressed as a matter of urgency. One staff member was trained in counselling. The training provided to staff was inadequate and did not support them in their work. This area required considerable improvement and was identified in previous inspection reports. A training audit should be carried out to identify deficits and a programme of in-house training should be provided. Staff attendance should be facilitated by the roster. A distinction should be made between training provided to special care staff teams and mainstream residential care with due regard to the nature of the work.

Inspectors recommend that the HSE should:

14. Complete a training audit and implement a programme of training suitable to meet the needs of the staff team working in a special care environment.

Safeguarding and child protection

On examination of Unit records, and during interviews with staff and children, it was evident that practice in relation to child protection was good. However, no training was provided. Inspectors recommend that guidance and training on these policies is provided as a priority.

Inspectors recommend that the HSE should:

15. Ensure that guidance and training on safeguarding and child protection is provided to staff in the Unit.

Care plans and reviews

The standard on care planning and statutory reviews was partly met. Two children did not have their reviews updated on a monthly basis as required by the Standards. The children told inspectors that they attended their reviews and had opportunities to express their opinions regarding their care placements.

Inspectors recommend that the HSE should :

16. Ensure that statutory care plan reviews occur on a monthly basis for children in special care.

Social work role

Each child had an assigned social worker. Inspectors found that outside of monthly reviews held in the Unit, the frequency of visits was limited. This was due in part to the distance between the placing area and the Unit. Social workers highlighted to inspectors the positive relationships staff members had with children. Some were concerned about the lack of therapeutic interventions. One social worker highlighted the need for improved inter-

disciplinary communication in decision making and agreeing how some information should be shared with the children. The majority of children spoke highly of their social worker.

Access to information

The standard on access to information was partly met. Children read their log books on occasions and were supported by the staff members in do so. However, some were not aware of their right to access their care files. Inspectors recommend that the right to access information is promoted and facilitated and that records are maintained in a manner to support this. There was no brochure for the children with information about the Unit. Staff members should ensure that information about the service, the rights of children and organisations that promote these rights are available to the children.

Inspectors recommend that the HSE should:

17. Ensure that children are consulted about the daily routines of the Unit and that information about the service, their rights, including organisations to promote their rights, is available to the children.

Health

The children had access to a general practitioner (GP) and specialist services external to the Unit. The HSE should review the GP service to ensure that it is appropriate to meet the needs of the service and the children.

Inspectors recommend that the HSE should:

18. Review the current GP service to ensure it meets the needs of the service.

Education

The standard on education was partly met. There was a school room in the Unit resourced by teaching staff under the direction of a school principal. There was evidence that the children were actively encouraged in their education. This service was not inspected by the Department of Education and Skills and did not a school status. The HSE should liaise with the Department of Education and Skills to establish the status of the school in a similar manner to the other special care units.

Inspectors recommend that the HSE should:

19. Establish the status of the school with the Department of Education and Skills.

Transport

The Unit had three cars to transport children and staff members around the country. The Unit Manager and the Monitoring Officer highlighted serious concerns about the road worthiness of two of these vehicles. Considering the amount of travel with children in this service, the HSE South should assess the safety of these cars and take steps to ensure that children and staff members are using safe, roadworthy cars.

Inspectors recommend that the HSE should:

20. Assess the safety of the cars in use in the Unit and take any necessary steps to ensure the transport used by the children and staff team is roadworthy and safe.

2.3 Practices that did not meet the required standard

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

3. Summary of recommendations

Inspectors recommend that the HSE should:

1. Immediately stabilise the management of the Unit to ensure it is sustainable and the Acting Manager adequately supported.

2. Resolve the current management issue and put in place a long-term management solution.

3. Ensure that the change management process is well managed through good communication and sharing of information with local management and staff members.

4. Ensure that specialist human resource support is provided to management.

5. Ensure that all staff members receive supervision as a matter of urgency.

6. Ensure that the statement of purpose and function is reviewed to define its role within the national child care service including the therapeutic model of care.

7. Ensure that the purpose and function should reflect how the Special Care Unit will work with families.

8. Ensure that children receive adequate emotional and specialist support to address their unsafe behaviour which necessitated their placement in special care.

9. Ensure that the post of shift coordinator is established without further delay.

10. Ensure that the roster and deployment of staff are reviewed so as to facilitate full staff meetings and a training programme.

11. Address inconsistencies in practices between teams in the Unit through improved communication and increased accountability in care practices.

12. Ensure that adequate information is provided about each child on their admission.

13. Ensure that there is a case management review process for children who have two or more placements in special care in a short period of time.

14. Complete a training audit and implement a programme of training suitable to meet the needs of the staff team working in a special care environment.

15. Ensure that guidance and training on safeguarding and child protection is provided to staff in the Unit.

16. Ensure that statutory care plan reviews occur on a monthly basis for children in special care.

17. Ensure that children are consulted about the daily routines of the Unit and that information about the service, their rights, including organisations to promote their rights, is available to the children.

18. Review the current GP service to ensure it meets the needs of the service.

19. Establish the status of the school with the Department of Education and Skills

20. Assess the safety of the cars in use in the Unit and take any necessary steps to ensure the transport used by the children and staff team is roadworthy and safe.

4. Conclusions

The inspection found that many of the *National Standards for Special Care* (2001) were met and found evidence that children were well cared for. There was also evidence of child-centred culture and practice.

However, the key areas of concern for inspectors related to the sustainability of the temporary management arrangements in place since August 2010. The HSE immediately responded to these concerns and a temporary deputy manager was appointed.

The governance of this Special Care Unit, in the context of the national special care services, is of utmost concern to the Authority. The planned transfer of the Unit from regional HSE South management to national HSE management under the umbrella of the Regional Director of Operations HSE Dublin North East has not occurred. There is no clear evidence of a national strategy for special care services and no one person in charge of the special care units. The capacity and responsibility of the management team in the HSE South to make decisions pertaining to the management of the Unit is unclear and this makes the current arrangement unsafe.

5. Next steps

The Authority has undertaken coordinated and simultaneous inspections of all three Special Care Units in Ireland which form the national special care service. In conjunction with the inspection reports of the three Units, the Authority has published an overview of the special care services in Ireland, *National Overview Report of Special Care Services Provided by the Health Service Executive* (Report ID Number 592). Therefore, this report should be read in conjunction with the two other inspection reports: Coovagh House Special Care Unit (Report ID No. 590) and Ballydowd Special Care Unit (Report ID No. 591) and the Overview Report. These reports are on the Authority's website, www.hiqa.ie.

This full inspection of Gleann Alainn Special Care Unit informs the Authority's national Overview Report on special care services provided by the HSE. The Overview Report considers key themes identified during the inspections of the three Special Care Units and will inform the Authority on the recommendations which will be specific to the national special care services. The national recommendations contained in this Overview Report will be directed at the HSE.

The completed reports on all inspections by the Authority of the three Units and the Overview Report will be issued to the Minister for Health and Children and to the Minister for Children and Youth Affairs. The Authority will request an action plan on all of the recommendations contained within these reports from the HSE within 10 days of their publication. The Authority will also request a monthly progress report on the implementation of these HSE actions.

The Authority will again report to the Minister for Health and Children within three months of publication of these reports on the status of the implementation of the Authority's recommendations and the resulting HSE action plans.

Appendices

Appendix 1
National Standards for Special Care (2001)

Standard 1. Purpose and function
The unit has a written statement of purpose and function that accurately describes what the unit sets out to do for children and the manner in which care is provided. The statement is available, accessible and understood. The unit's role in relation to the wider child care services (including regional and national) is clearly set out by the Health Service Executive.

Standard 2. Management and 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 children. The unit is effectively managed and staff are organised and deployed so as to operate the unit effectively and efficiently to the required standard.

Standard 3. Monitoring
The Health Service Executive has adequate arrangements in place to enable an authorised person, on behalf of the Health Service Executive to monitor statutory and non-statutory children's residential centres.

Standard 4. Planning for young people
There is a written care plan to promote the welfare of each young person which is subject to regular review. This stresses and practically supports contact with families, preparation for adulthood, promotes education and health needs and addresses the emotional and psychological needs of the children.

Standard 5. Care of young people
Children are cared for by staff who can relate effectively to them. Day-to-day care is of good quality and provided in a way which takes account of their individual needs in relation to age, race, culture, religion, gender and disability. Children are cared for in a manner which safeguards and actively promotes their legal and civil rights. Children whose conduct is unacceptable are dealt with in accordance with positive disciplinary measures approved by the Health Service Executive.

Standard 6. 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 which is, in so far as practicable, appropriate to its designation as a children's home. It must also be properly maintained and furnished.

Standard 7. Education

Education should be seen as an integral part of the care of the young person. The education of all children should be actively promoted by all involved. In so far as it is practicable, units should aim to provide for those of school age, a broad and balanced curriculum appropriate to their age, ability and level of attainment with a view to continuing in open conditions or a return to mainstream school. Where appropriate, children over the age of 16 should be offered a programme where vocational preparation, training and work experience or transition to further education.