SOCIAL SERVICES INSPECTORATE

GLEANN ALAINN SPECIAL CARE UNIT IN THE SOUTHERN HEALTH BOARD

INSPECTION REPORT ID NUMBER: 9

Publication Date: 18 Aug 00
SSI Inspection Period: 1
Centre ID Number: 99

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1: Introduction

The Irish Social Services Inspectorate is empowered, under Section 69 of the Child Care Act 1991, to inspect the social services functions of health boards, including children's residential centres.

In line with this requirement Dr. Mike Lindsay and Michele Clarke carried out an inspection of Gleann Alainn Special Care Unit.

The unit was established in 1995 as a special care unit, in the grounds of St. Stephen's Hospital, to serve the Southern Health Board region (Cork and Kerry) and as a specific response to an individual case before the High Court. It provides short-term care for girls aged 12 to 16 years. At the time of the inspection, Gleann Alainn accommodated four girls from the Southern Health Board and one girl placed by the South Eastern Health Board. The intention is to extend Gleann Alainn increasing its capacity from five to seven girls. This will enable Gleann Alainn to provide a regional service for the Southern, Mid-Western and South Eastern Health Boards.

1.1 Dates and times of inspection

The inspection was carried out over three days on the 11th, 12th & 13th April 2000. The inspectors held a pre-inspection meeting with the unit manager, staff and girls of the unit on the 7th April 2000. Dr. Mike Lindsay and Andrew Fagan further visited Gleann Alainn on 20th July 2000.

1.2 Documents reviewed in the course of the inspection

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

- Policy and procedures document (1999)
- Health & safety policy statement (1999)
- Draft development plan (1999 – 2004) for the Education Unit
- Log book
- Each girl's case file
- Reports and written information on complaints
- Fire and security log book
- Sanctions book
- Daily diary
- Incident sheets
- Complaints forms
- Use of restraint forms
- Isolation report forms
- Weekly points sheets
- Sanctions forms
- LSI (life space interview) forms

- Information collated from questionnaires completed by a parent, a teacher and two social workers
- Census forms on staff members
- Census forms on the girls

1.3 Observation and participation

Inspectors observed the daily routines of the unit and took meals with staff and girls. They toured the unit, and its grounds, and two girls showed inspectors their bedrooms. Inspectors also attended the weekly staff meeting.

1.4 Interviews conducted

Interviews were carried out with the three girls that were present and two parents (one of these by telephone). Two girls were absent for much of the inspection because they had absconded. As part of the inspection interviews were held with social workers, managers and residential care staff. Inspectors further interviewed the teacher in charge and a consultant psychologist whose work includes significant input into the unit.

1.5 Acknowledgements

Inspectors acknowledge the assistance and co-operation of all staff at Gleann Alainn and within the Board during the course of the inspection. They found that people responded openly and were prepared to examine their practice. Inspectors thank the unit manager and staff at Gleann Alainn for the hospitality and support shown.

Some social work staff travelled long distances and arranged their working schedules to facilitate meeting with us, and this was appreciated.

The inspectors extend their thanks to the parents for taking time to talk with us and reserve special mention for the girls for the generous manner in which they accepted our intrusion into their lives.

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

2.1 Children/young people

2.1.1 Data collection

Census forms on all five girls resident at the time of the inspection were completed on the 20th March 2000.

2.1.2 Age range

At the time of inspection, one girl was 12 years old, two girls were 14 years old, and two other girls were both aged 15 years.

2.1.3 Legal status of care placement

Four of the girls were in care under wardship proceedings, whilst the fifth was the subject of a high court order. The legal status of all five provided authority for their detention within a 'special care unit'.

2.1.4 Length of time in current placement

One girl had been at Gleann Alainn for eleven months, whilst two others had both been there for seven months. The two remaining girls had been in the unit for five and six weeks respectively.

2.1.5 Care status of siblings

Of the group of five girls living in the unit all had siblings who were or had been in care at some time in their lives. One of the girls had five siblings in care, two of whom were in other residential centres and three in foster care. Two of the others each had a sibling in residential care and a fourth girl had a sibling in foster care.

2.2 Management structure

The management structure within the unit consisted of one unit manager who worked off shift and supervised the work of all care staff. An acting deputy unit manager assisted her in this task. The unit also deployed shift co-ordinators who were selected from within the permanent, and long-term temporary, staff group. This task was equitably shared out amongst them and each of these staff members was required to carry out shift co-ordination responsibilities every three months. Shift co-ordinator was not a formally recognised post within the Board, but the additional responsibilities were in lieu of the fact that all the permanent staff were employed, and remunerated, at the level of houseparent grades.

A management committee, comprised of the consultant psychologist attached to the unit, a senior social worker (child psychiatry), the child care manager, a staff officer and the unit manager, met every two months to support the running of the unit.

Teaching staff in the unit were managed by a teacher-in-charge and employed by the Vocational Education Committee, through existing Department of Education and Science funding.

The unit manager at Gleann Alainn was line-managed by the child care manager, who in turn reported to the general manager.

3. Standards: the Findings

3.1 Statement of purpose and function

The centre has a clear written statement of purpose and function, which accurately describes what the centre sets out to do with children and the manner in which this is provided.

Gleann Alainn has a written statement of purpose and function which inspectors regard as meeting the standard. This is set out in an impressive and detailed policy and procedures document, which was originally produced in 1995 and last revised in 1999. The unit's stated purpose is; *"the provision of 'a controlled and safe environment' for children for whom such provision is considered necessary by the Court."* It then underpins this statement by establishing as its overall objective; *"to enable the children in our care to move to open care situations"* and the document goes on to advise how Gleann Alainn aims to do this;

- *Providing an environment which is caring, secure, safe and conducive to learning.*
- *Assisting in the development in each child a sense of self-esteem, self-discipline and respect for others.*
- *Attempting to meet the physical, emotional, social and educational/training needs of children in its care.*
- *Implementing each child's individual placement plan.*

Inspectors consider this to be a fair statement of purpose and function, enabling staff, managers and other professionals to focus on a clear set of objectives, but it can be improved.

The first clear reference that Gleann Alainn is a unit for girls is in the admissions criteria, set out in appendix on the very last page of the document. The statement would be better if it emphasised, from the outset, its purpose to admit girls. Gleann Alainn is a special care facility, and part of its function involves restricting the liberty of girls in its care. The statement of purpose and function would be more adequate if it acknowledged the security aspects of the unit's role.

The unit was in the process of updating its information booklet, for girls, parents, social workers and others, and inspectors suggest that this should include a statement of its purpose and function. This is of particular importance for those who are not already familiar with the unit and would provide useful information for girls, parents, social workers, service planners and the courts.

The unit's treatment approach was described as eclectic, combining applications mainly derived from behaviourist and psychoanalytical methods. A statement outlining the unit's therapeutic function would be a useful addition to the document.

RECOMMENDATIONS

1. **The unit should ensure that its statement is more explicit in defining that its purpose is for girls and one of its functions is to restrict their liberty.**

2. **The unit should clarify its therapeutic function.**

3.2 Working in partnership

Partnership is essential to the provision of good quality residential childcare. The experience of young people in care is enhanced by positive working relationships between professionals

Inspectors regard this standard as having been broadly met. Gleann Alainn place great emphasis upon working in partnership and inspectors observed that there were good relationships maintained with social work colleagues and other agencies. Good communication existed between residential child care staff and social workers and they regarded each other with mutual respect. They worked closely together, trying to ensure that girls do not have to remain in the special care unit any longer than necessary. While residential child care staff kept social workers informed of incidents affecting the children for whom they carry responsibility it was noted that they did not always back up verbal accounts in writing. For both residential child care staff and social workers a common concern was the lack of alternative placements being available, with the result that some girls may have remained at Gleann Alainn longer than

considered necessary. They also shared common concerns that essential support services were not always available when needed. This situation occasionally impacted upon the generally good working relations, as a few residential child care staff interpreted the lack of placements and community based services as indicative of insufficient effort on the part of some social workers.

Education and child care staff generally worked well together but there were occasional tensions between them. Examples include the use of classroom equipment by child care staff (such as a computer) and disputes about girls being out of school (either being kept out by child care staff or sent out by a teacher).

Good working relationships had been forged with the consultant psychologist, who provided direct work with girls, and consultancy to staff. He also provided supervision support to Gleann Alainn's management team.

3.3 Admissions criteria and policy

The centre has an established policy, setting out how young people are referred and admitted.

The unit meets the requirements of this standard, but inspectors consider that there is room for improvement. It has a written admissions policy that clearly sets out criteria for admission, tasks to be completed prior to admission and how a new resident should be received into the unit. The policy represents a very considered approach being sensitive to feelings of separation and loss that the girl may experience when first admitted. Considerable emphasis is placed upon showing kindness and respect to new arrivals, conveying a message that staff would like their stay to be *"…as pleasant as possible"*.

Opportunities were provided for girls to visit the unit prior to admission and the unit manager confirmed that all current residents had done so. Inspectors welcomed Gleann Alainn's practice of providing pre-admissions visits. The unit encourages, where appropriate, families to play an active part in the admissions process. This was a vital aspect of helping newcomers to settle in the unit.

The policy outlined a detailed set of security, administrative and medical procedures. These include a full admissions search[1], a check of all personal possessions, confiscation of restricted items, a pregnancy test and a blood test. Whilst inspectors appreciated the unit's need for security this must be constantly balanced against the image that Gleann Alainn is trying to convey to new arrivals. Girls had already formed initial impressions as they enter the

[1] Description provided on page 34

grounds and building. They were conscious of entering a unit whose purpose was to restrict their liberty and, in many instances, they did not know for how long. Inspectors considered that, at present, girls were unlikely to perceive their admission to Gleann Alainn as welcoming owing to the unattractive physical appearance of the building, its décor and its setting within the grounds of a hospital. A girl's experience of admission will be enhanced by the significant renovations which were being undertaken. Most of the girls currently in the unit were admitted from other care establishments. Of the last eighteen admissions to Gleann Alainn fifteen girls had come directly from care placements, two had been previously homeless and only one had been admitted straight from home.

Admission to the unit requires a successful application to the High Court or Circuit Court. The most usual method for the Southern Health Board was to apply for the girl to be made a ward of court. Inspectors were told that girls were usually legally represented in these proceedings and it is board policy that this should be so. Since Gleann Alainn opened there had been only one exception to this, and concerned a girl placed from outside of the Southern Health Board. At Gleann Alainn's own insistence this girl was, subsequent to being placed, provided with separate legal representation. The Children Bill 1999 will have a considerable bearing on how young people can be admitted to special care units in the future, and inspectors were encouraged by the extent of work that managers had already done to prepare for its effective implementation.

RECOMMENDATIONS

3. Gleann Alainn should progress work on upgrading the physical appearance of the building as this will contribute towards making the unit a more welcoming place to be admitted to.

4. Gleann Alainn should explore ways of finding a better balance between routine security procedures and the need to be welcoming.

5. All girls admitted to Gleann Alainn should have access to separate legal representation, regardless of which board seeks to have them placed there. The Southern Health Board should develop protocols with other placing boards to ensure that this happens.

3.4 Care planning and review

3.4.1 Care plans

Each young person's care is subject to a formal, systematic and written plan to promote the welfare of the child in compliance with Article 23 of the Child Care Regulations 1995.

Inspectors are concerned that current practice falls short of the required standard. There is a written care plan for each girl. However, current care plans fall short of the required standard in a number of respects. They are not completed by the social worker before admission to Gleann Alainn. There is little evidence of consultation by social workers with young people, parents, residential child care staff and other relevant people before the plans are formulated. The plans generally lacked detail and provided little indication of what work was being undertaken outside of Gleann Alainn (i.e. with families, with community support services, with alternative placement providers etc.). The care plans found fell into two broad categories. Most were set out in the form of a table, with bullet-points and headings used to itemise each girl's needs. By way of contrast, one social worker had developed a very detailed and elaborate care plan based upon the 'Looking After Children: Action and Assessment Recording' materials, developed in England. This latter model was being piloted within the area, with a view to being introduced more widely into practice. Inspectors commend this new initiative and view it as a positive development that will improve the care planning process.

A number of other social workers were relying upon the work done by residential child care staff in producing placement plans for each girl, in preparation for a placement meeting. The placement meeting comprised members[2] of the case management team, the girl and her family. The placement plan considered the care and educational objectives, professional roles, expected time-scales for placement and possible future options, levels of security required, home visits and outside trips. One social worker offered her opinion that the placement plan contributed significantly to defining the girl's care needs and setting out how these were to be met. Inspectors support this view of the work done by Gleann Alainn to produce placement plans. However, this work was not in itself an adequate substitute for a care plan.

There was not an initial assessment of each girl, designed to inform professionals about the extent and nature of problems that may need to be addressed. Clinical psychologists, educational psychologists, special education and psychiatric services had undertaken some assessments, where girls had previously been referred to these. Inspectors consider that the care planning process would benefit from a formal multidisciplinary assessment of

[2] The case management team is made up of the unit manager, senior social worker or team leader, area social worker, key-worker and teacher.

girls' needs. This assessment should be commenced upon arrival, completed within one month and a report produced to shape all future planning.

RECOMMENDATIONS

6. The Board should ensure that written care plans are being produced in line with the requirements of Article 23 of the Child Care Regulations 1995. These should augment work being done on placement plans and where practicable be in place prior to admission.

7. The development of care plans should be informed by a multidisciplinary assessment of each girl's needs.

3.4.2 Review of care plans

Each young person's plan is reviewed by an authorised person as often as may be necessary in particular circumstances, but in any event at intervals not exceeding those specified by Article 25 of the Child Care Regulations 1995.

Notwithstanding points made about care planning, Gleann Alainn policy exceeds the requirements of both this standard and regulations by stipulating monthly reviews. Inspectors were satisfied that this policy was being consistently applied in practice and regard the effort put into this as creditable.

Those invited to attend are specified as the case management team members, "relevant family members" and other persons thought to be appropriate. The policy stated that girls could be invited in at the end if this was considered to be appropriate. It identified the purpose of the meeting, including a formal review of the care plan; security; family contact; significant developments and progress and professional roles.

In practice there existed a two-tier system for reviewing the girls care plans.

- Internal case reviews were organised and chaired by Gleann Alainn and, in accordance with unit policy, these are held monthly. Social workers give a verbal input to the review meeting.

- Statutory reviews were arranged by social workers, chaired by a senior social worker and take place every six months. Social workers provide a written report in preparation for these.

The frequency of case reviews was impressive. This ensured that the matter of each girl's restriction of liberty was constantly under consideration and enabled the ongoing planning process to be responsive to dates specified by the court reviews.

There was a written policy in place encouraging girls' involvement in care review meetings. Inspectors however, observed one particularly poor example of this, from a girl's perspective. It was over 1½ hours before the girl concerned was invited to join the review. It was explained to inspectors that the delay had been caused by the need to resolve some professional differences. More importantly, professionals took time after the review to explain and express regret to the girl for the way she had been kept waiting. Her sense of inconsequence, as a child, was reinforced by the fact that the meeting permitted her mother to participate throughout. Inspectors were impressed that professionals involved were able to recognise the distress caused to the girl by her exclusion from a significant portion of her review. They responded appropriately to this and gave an undertaking to settle any future differences outside of the review setting. Inspectors emphasise the principle that the participation of young people in decision-making is both a right and an essential element to good child care planning. Gleann Alainn would underpin its practice in this regard if it ensured that where girls attend their care review meetings this is clearly minuted.

RECOMMENDATIONS

8. Girls should be permitted to attend as much of their care review meetings as is practicable.

9. Girls and parents should routinely receive copies of minutes from care review meetings.

3.4.3 Family involvement

The centre shows respect for the young person's family in all aspects of how it cares for young people. Parents are involved in planning for young people's everyday life and future.

The unit went some way to meeting this standard. Gleann Alainn's policies and procedures document devotes a whole chapter to contact with family which it regards as essential. It sets out in detail how this should be maintained through telephone calls, letters, visits to the unit and home leaves. At the time of the inspection all of the girls had contact with their families. Two girls had contact on a weekly basis, two others had fortnightly contact and the fifth girl had contact on a monthly basis. Girls at Gleann Alainn were usually able to start taking home leaves after one month of being admitted to the unit, subject to home circumstances. Gleann Alainn was proactive in creating possibilities for girls to participate in home leaves and engage in other activities outside the unit. Inspectors however, caution that Gleann Alainn needs to be able to demonstrate that a proper balance is being struck between the benefits which the girls are deriving from this, and the heightened risks associated with the greater opportunities for unauthorised absences. A formal

written assessment of each girl's needs would help make the rationale behind these risk-taking decisions more transparent and professionally accountable.

The unit operated a fairly liberal policy on phone contact with family and visits. These were well facilitated and arrangements were left as much as possible for the girls and their families to determine. Inspectors were told that residential care staff tend to intervene only if a girl or her family does something to suggest that they cannot be trusted. There were facilities for girls and parents to be given some privacy during visits, but this was inevitably dependent upon security.

Gleann Alainn did not have any facilities to enable families to stay overnight and might wish to explore this possibility. Inspectors found documented and actual evidence of family involvement in decision-making. During the course of the inspection, one mother participated in a case review meeting, whilst another accompanied her daughter who had returned from a period of unauthorised absence. Inspectors saw that residential care staff and social workers gave parents their say and took on board their concerns.

Visiting the unit was emotionally difficult for some parents. One mother expressed strong feelings about her daughter being locked up and subject to a regime of security. Some parents travelled considerable distances to get to the unit and were unable to maintain the level of contact they would like, whereas inspectors heard from staff and social workers that other parents did not maintain a consistent interest in their daughters. Encouraging ongoing family contact was difficult and inspectors found all parties worked hard at this. There was a recognition that family may provide these girls with their only significant source of contact with the outside world. Inspectors considered that the Southern Health Board offered useful support to parents, but concluded that all three boards could be more proactive in advising parents how some of their travel and overnight expenses might be met. A simple leaflet setting out entitlements would improve the situation and the matter could be looked at as part of the admissions process.

RECOMMENDATION

10. All three boards should explore practical ways of supporting family contact and be more explicit about how reasonable expenses incurred by family members visiting the unit might be met.

3.5. Staff recruitment and support

3.5.1 Recruitment

Staff are the most vital resource in providing quality care. They will be among the most important people in the child's life while in residential care. Recruitment, training and support policies should recognise this and should ensure that staff are equipped to fulfil their duties to children. The personal and professional skills, which staff bring to the task of caring for children, should create a living environment, which is child-oriented.

Inspectors are satisfied that this standard is being met. Recruitment to special care units is particularly difficult as it can be one of the most stressful environments for staff to work in. Gleann Alainn has succeeded in bringing together a well-qualified staff group, with a good range of abilities and experience. However, only four hold recognised professional qualifications as identified by the Department of Health and Children.

Residential care staff were selected in accordance with the standard recruitment procedures of the Board. All posts required the completion of an application form, which were in some cases supported by curriculum vitae. Successful candidates had completed satisfactory Garda clearances, provided suitable employment references, provided evidence of qualifications held and undertaken formal interview.

Inspectors noted that nearly half of the existing staffing complement was made up of permanent staff, which has contributed towards maintaining a stable workforce.

3.5.2 Staff support

Young people are looked after by staff who are trained in the skills necessary to meet their needs and, who receive appropriate professional support from management for the tasks that they are required to carry out.

Inspectors were satisfied that this standard is being met.

The staff group has regular weekly team meetings that support the work of the unit and provide a forum for communication. They enable staff to discuss the progress of the girls and matters affecting the running of the unit.

Staff appreciated the support they received from within their shift

teams and had built up a great deal of professional trust and confidence in working with each other.

There were some concerns amongst staff about the possibilities of their being subject to false allegations by the girls. This may have been exacerbated by the fact that one staff member had been suspended on a precautionary basis pending the outcome of an investigation against him. Inspectors noted a degree of reticence on the part of some staff in their interactions with the residents. It was clear, however, that staff worked together and were careful to provide cover for each other to limit the possibilities of unfounded allegations being made. In reality there was little actual evidence, past or present, of staff at Gleann Alainn being at risk from such allegations. The one member of staff who had been suspended was being investigated in relation to matters which pre-dated his time at Gleann Alainn. There were no other examples of disciplinary action being taken out against staff as a direct consequence of a complaint. The apprehension that staff had about the potential consequences of having allegations made against them was understandable, but not grounded in fact.

Staff had access to the services of the employment assistance officer and were encouraged to use these particularly for critical incident debriefing.

3.5.3 Staff rota

The general shift pattern involved four staff working 8am – 2pm and another team of four working 1pm – 11pm. Two of the staff in the team working the late shift, worked until midnight and did the sleepover for that evening. Staff also worked waking night duties, on a periodic basis of three months, which some said gave them a welcome break from the day shift. There were three shift teams which each had a shift co-ordinator. This task was rotated every three months enabling each permanent and long-term temporary member of staff to take turns at shift co-ordination. The unit's managers were considering reverting to the former structure of having an appointed team leader for each shift. A change in structure was likely because Gleann Alainn was increasing its present staffing levels from 21 to 27, to accommodate two more girls.

Gleann Alainn have tried to maintain a balance of male to female staff on the rota. However, one group of staff interviewed expressed their opinion that there were a number of tasks that were not considered appropriate for male care staff to carry out. Physical restraints, 'pat searches' and issuing sanitary protection were three examples given. In practice, records showed that male staff had occasionally applied physical restraint, but they were never involved in searches or issuing of sanitary protection.

3.5.4 Qualifications, status and experience of staff

The total number of staff working at Gleann Alainn was twenty-one, a manager, a deputy and nineteen child care staff, with a range of job titles. There were eighteen female members of staff, including the manager and deputy, and three men. Nine of the staff had worked in the unit for two years or more, although eight others had less than nine months experience. Gleann Alainn was served by a well-qualified staff group, consisting of eight graduates and twelve holders of various vocational qualifications. They offered a broad range of specialisms and a balanced workforce in respect of their experience. Gleann Alainn had succeeded in recruiting a number of staff with previous experience in child care work, in addition to attracting new recruits to the profession. Inspectors considered that the staff group at Gleann Alainn provided a varied combination of qualifications, training and relevant experience but should have a greater proportion that hold qualifications which comply with national guidelines. Four staff held professional qualifications recognised by the Department of Health and Children as required by staff working at houseparent grades in residential childcare. Staff were given various job titles which were not reflected by any differences in job description or function.

TABLE 1. ***Qualifications and status of staff***

Staff	Qualifications
#1 Manager	*Bachelor of Social Science degree and Higher Diploma in Social Work*
#2 Acting Deputy Manager	*Cert. & Diploma in Youth & Community work, Diploma in Applied Social Studies and Social Care and City & Guilds in Supervisory Management*
#3 Child care worker	*Bachelor of Social Science degree*
#4 Houseparent	*Diploma in Applied Social Studies in Social Care*
#5 Care worker	*Diploma in Health Studies and Registered Mental Handicap Nurse*
#6 Care worker	*NCVA level 2 Diploma in Montessori teaching*
#7 Care worker	*Bachelor of Social Science degree*
#8 Care worker	*Cert. & Diploma in Applied Social Studies in Social Care*
#9 Care worker	*Bachelor of Arts degree and Higher Diploma in Education*
#10 Assistant houseparent	*NCVA in Community Health Care*
# 11 Assistant houseparent	*Bachelor of Social Science degree and Master of Social Science degree*
#12 Child care worker	*Registered General Nurse*

#13 Care worker	*Bachelor of Social Science degree and City & Guilds in Child Care*
#14 Care worker	*Diploma in Applied Social Studies in Social Care*
#15 Child care worker	*Diploma in Youth & Community Work*
#16 Child care worker	*Paediatric Nursing*
#17 Assistant houseparent	*Bachelor of Social Science degree*
#18 Assistant houseparent	*Cert. in Applied Psychology & Social Studies*
#19 Assistant houseparent	*Bachelor of Social Science degree*
#20 Assistant houseparent	*Cert. in Applied Social Studies in Social Care*
#21 Care worker	*Registered Mental Handicap Nurse and State Registered Nurse*

TABLE 2. ***Length of staff service in Gleann Alainn and in child care in total***

Staff	**Length of service in Gleann Alainn**	***Length of service in child care in total***
Manager (F)	*4 years, 6 months*	*8 years*
Acting deputy manager (F)	*3 years*	*3 years*
Child care worker (M)	*3 months*	*1 year*
Houseparent (F)	*2 years, 7 months*	*7 years*
Care worker (F)	*2 years*	*12 years, 6 months*
Care worker (F)	*1 month*	*6 years, 6 months*
Care worker (F)	*2 years, 6 months*	*2 years, 6 months*
Care worker (F)	*2 years, 1 month*	*2 years, 1 month*
Care worker (M)	*4 months*	*3 years*
Assistant houseparent (F)	*1 year*	*2 years, 6 months*
Assistant houseparent (F)	*7 months*	*5 years, 7 months*
Child care worker (F)	*2 years*	*23 years*
Care worker (F)	*2 years, 2 months*	*5 years, 2 months*
Care worker (F)	*2 years, 3 months*	*2 years, 10 months*
Child care worker (M)	*16 months*	*16 months*
Child care worker (F)	*3 years, 8 months*	*9 years, 8 months*
Assistant houseparent (F)	*9 months*	*9 months*
Assistant houseparent (F)	*5 months*	*5 months*
Assistant houseparent (F)	*1 year, 2 months*	*2 years*
Assistant houseparent (F)	*5 months*	*5 months*
Care worker (F)	*6 months*	*6 months*

RECOMMENDATION

11. The Board should ensure that an increased proportion of staff employed in Gleann Alainn hold, or be facilitated in acquiring, recognised qualifications in child care.

3.5.5 Supervision

The unit manager received supervision from two separate sources. There was formal supervision from the child care manager and "professional" supervision from the consultant psychologist attached to Gleann Alainn.

The unit manager in turn supervised the acting deputy unit manager. However because they communicate very closely on a daily basis, this rarely involved formal, planned supervision.

The staff received team supervision every six weeks from either the unit manager or the acting deputy unit manager. Individual supervision happened, but not always consistently unless a staff member asked. Gleann Alainn managers told inspectors that individual supervision of staff will become one of the team leader functions, when this role is reintroduced.

The unit organised monthly group supervision and "team days" every two months, which social workers supported by taking the girls out or occupying them in other ways. Team days provided the whole staff group with opportunities for professional development and included input from a senior social worker and an outside facilitator. Staff for the most part staff considered that team days provided excellent opportunities for learning. Staff stated that they generally found team days very useful and a "safe way to explore practice issues". Inspectors regarded this as an innovative approach to team development.

3.5.6 Induction

The unit did not have a formal, structured programme of induction, but new staff were closely mentored by more experienced colleagues. They were also guided by managers to familiarise themselves with the policies and procedures of the unit.

3.5.7 Training and staff development

Both the unit manager and the acting deputy unit manager have received recent in-service training on the Child Care Act 1991 and courtroom skills and procedures.

Overall, all staff had undertaken the four-day training programme in therapeutic crisis intervention. Seven of the staff group (including the unit manager) had done so within the last twelve months.

One member of staff had attended a seminar on domestic violence whilst one of her colleagues took part in a fire and safety course.

Staff have had limited training opportunities at Gleann Alainn, which was a product of the dearth of training which was available within the board. In spite there being an academically and vocationally well-qualified staff group inspectors believed that ongoing training was essential. The appointment of a child care training officer was imminent and it was anticipated this would enable more training opportunities to be made available.

RECOMMENDATIONS

12. Staff should be provided with a formal programme of induction, supervision and ongoing training to best equip them for the tasks they are required to carry out.

13. These should happen frequently and inspectors recommend that the unit undertake an audit of staff training needs as a precursor to drawing up a training action plan.

14. Individual supervision should be regular and guaranteed.

3.6 Children's rights

Gleann Alainn had a written statement of the rights that girls in the unit can expect. These consisted of;

- *The right to respect*
- *To be cared for in a planned way*
- *To a recognition of their individuality*
- *To be cared for within an explicit care and control policy*
- *To be protected*
- *Access to a complaints procedure*
- *Access to education*
- *Access to health care*
- *To training in life skills*

It is commendable that the unit had produced such a statement. Gleann Alainn's statement would be improved by including recognition of children's rights to be consulted and involved in decisions affecting their lives. The statement should address children's rights concerning access to information about themselves and contact with family. Article 37 of the United Nations Convention on the Rights of the Child (1989) provide for special rights that

require that children are only detained as a last resort and then, for the minimum period necessary. Gleann Alainn's statement should reflect this.

3.6.1 *Consultation*

Young people's views are sought over key decisions, which are likely to affect their daily life and future.

Inspectors noted that girl's views were sought over key decisions but did not always influence outcomes as much as they might have done. This was in part because they were permitted to be involved at review meetings only at the end. The unit's written policy on reviews specified that girls should be invited to attend the end of their review and then only if deemed appropriate. The policy did not recognise their involvement as a right or indicate how their views were to be sought. However, Gleann Alainn had produced a set of review forms intended to elicit each girl's views. Practice indicated that these were not consistently completed but where they had been, the forms helped girls to focus on what they wanted to say at their review meetings.

In contrast, the official policy stated that girls should be invited to an admissions meeting which was used to form the placement plan. There was documented evidence that girls had fully taken part in admissions meetings. This model of involvement complied with the requirements for the standard on consultation.

The girls had weekly house meetings chaired by the shift co-ordinator. Policy stipulates that; *"The agenda for the meeting is set by the young people and the staff present and its aim is to enhance the service provided through sharing of responsibility and listening to the children in the unit"*. Staff said that when these started they were just a 'wish list', but have become more focused on discussing issues for the unit. Inspectors heard from girls and staff that house meetings were used mainly to sort out activities girls wanted to have arranged and clothing items that they needed. The girls said that when they raised issues to do with the running of the unit they did not always receive feedback from the staff. Inspectors concluded that the weekly house meetings provided a good opportunity for Gleann Alainn to give an effective and genuine forum for the girls to have a voice. However, further work needs to be done to ensure that weekly house meetings are used to explore issues beyond activities. Feedback needs to be more consistently provided. Staff could enhance the whole process by advising the girls about items which are to be included for discussion at forthcoming team meetings and inviting their views on these.

RECOMMENDATION

15. Gleann Alainn, in conjunction with social workers and management, should draft a policy statement setting out how they propose to seek girls' views, and ensure that they are given due consideration.

3.6.2 *Complaints procedures*

Children in residential care need to be able to express their unhappiness or complain about their care.

Gleann Alainn had a written complaints policy that emphasised the right of girls to complain about any matters concerning their care or any other matters that they were unhappy with. This policy referred to a complaints procedure and a written copy was contained within a young person's booklet that Gleann Alainn were in the process of updating. Complaints could be notified to any care worker, the manager of the unit (or acting deputy unit manager) or social worker and the procedure required them to be sent to the senior social worker. Where a complaint was made the senior social worker, together with Gleann Alainn managers, investigated it and informed the girl, her parents and social worker of the outcome. The written complaints procedure required that a record of each complaint was made and retained on the girl's file.

The procedure did not set timescales for certain tasks to be completed and inspectors considered that it should have done. Complaints that were investigated under staff disciplinary, child protection or criminal procedures often involved a lengthy process and provided little ongoing feedback about progress, either to the girls or staff. During one such investigation a member of staff was suspended without pay. The allegations did not relate to Gleann Alainn, but were made in respect of a previous employment. Managers advised that the decision to suspend without pay was Southern Health Board policy and had been based upon legal advice that they had received pursuant of the High Court ruling in the case of Devery v. Southern Health Board.

Inspectors considered that the procedure only dealt with the most serious complaints, which induced some defensive attitudes amongst staff and discouragement to girls in respect of raising other concerns. Inspectors were given details of four formal investigations that had been carried out. Of these, one investigation was ongoing. It did not arise from any complaint from a girl within Gleann Alainn but through another member of staff. Two other investigations had been completed and determined that there was no case to answer. However, although these were initiated from complaints made by girls' they were not against any members of Gleann Alainn staff. The fourth investigation was the only one which involved a girl at Gleann Alainn making

a serious complaint against staff working in the unit. The investigation determined that the complaint against the member of staff was unfounded.

Given that Gleann Alainn has been open for five years there have been remarkably few complaints and certainly not the volume that would justify the amount of concern that some members of staff have about the complaints procedure. That said, inspectors consider that management should review present arrangements. Some staff revealed that they regarded the complaints procedure as a profoundly unfair system. From their perspective the system threatened their careers and treated them as though they were guilty until proven otherwise. Despite evidence to the contrary they perceived the complaints procedure was giving the girls far too much power, which could be used against staff. Managers need to consider the possibility that, in reality, staff fears were related to how complaints were perceived to be handled as distinct from the existence of the procedure itself.

The unit's policy included the statement; *"It is understood that the care worker needs to develop a relationship with the child which is based on openness, honesty and respect"*. Inspectors believe that the quality of professional relationships being formed with the girls was affected by staffs' fear of serious allegations or complaints. Staff were conscious of the circumstances of a colleague who had been suspended from duty whilst investigations continue (the allegations relate to a period of employment pre-dating the member of staff's time at Gleann Alainn). Each manager interviewed understood that complaints risked undermining the confidence of the residential care staff group. They conveyed a commitment to finding a more balanced approach to ensure that the complaints procedure provided an effective safeguard for the girls whilst respecting that staff also have rights.

The complaints procedure lacked impartiality and failed to provide an independent consideration of complaints. Whilst there was no formal requirement that it should, inspectors considered that this is essential if complaints were to ensure that girls consistently received a fair hearing. Complaints handling acted in breach of a fundamental principle of natural justice which requires that 'no person should be judge in their own cause'. This does not prevent complaints being resolved quickly and close to the point they arose. However, girls might not always be prepared to entrust their complaints to the very same people about whom they are complaining.

RECOMMENDATIONS

16. Managers should consider how they propose to resolve the lack of confidence that girls and staff have in the complaints procedure.

17. Managers should revisit their approach to handling complaints, ensuring that its procedures are sufficiently credible so as to contribute useful management information about girls' dissatisfaction with the service they receive.

3.6.3 *Access to information*

Young people are permitted access to significant sources of information about themselves and services available.

There was no written policy addressing the rights of girls in the unit to have access to information, including files. Girls received a booklet about Gleann Alainn on admission and were given a copy of their placement plan. Key-worker's often told girls what they had written about them, but inspectors regard this as a poor substitute for sharing the actual record with them. Social workers confirmed that the girls were unlikely to have seen their case files and were not routinely given copies of minutes from review meetings.

RECOMMENDATION

18. The board should develop a policy on access to information in line with the requirements of freedom of information legislation. This should set out how requests for access to personal files will be handled and encourage staff to routinely share written records with the girls.

3.7 Child protection and safeguarding issues

There are systems in place in the centre, which aim to ensure that young people are protected from abuse. In particular, staff are aware of, and implement, practices which are designed to safeguard young people in their care.

Inspectors found that this standard had been met.

Gleann Alainn had a well-written policy on child protection which is designed to help staff to understand their obligations under the child protection procedures, become familiar with signs of child abuse and facilitate them in expressing any concerns they might have about colleagues. The policy also required that the girls know about the child protection procedures and what actions will follow the reporting of abuse. Inspectors were provided with written accounts of how allegations had been investigated and formed the view that these provided a detailed consideration of the child protection concerns that they raised.

Recruitment procedures involved necessary checks to reduce the risk of employing persons who were unsuitable to work with children.

As indicated in paragraph 3.6.2, work needs to be done on the complaints procedure. At present it does not provide a convincing safeguard mainly because girls lack confidence in it.

Staff were particularly conscious of safeguarding practices around the unit and took care to ensure that girls were not put in situations of vulnerability.

3.8 Sanctions policy

Each children's residential centre sets reasonable limits which everyone understands on what is regarded as acceptable behaviour and what is not. Sanctions generally work best in an environment where children are commended and rewarded for the achievement of good behaviour.

The policy included a detailed section on "Boundary Management" which identifies a range of steps designed to help the girls to stay within acceptable limits. The policy emphasised that sanctions should be employed positively and not to punish the girls. Inspectors were impressed with this policy which represents an impressive array of approaches to behaviour management. It underlined the importance of girls understanding the unit's expectations of their behaviour and how this will be responded to if deemed inappropriate. Staff informed inspectors that they related sanctions to behaviour in a way that helps girls to see that there are "logical consequences". Examples offered included girls paying for breakages and not being allowed use of the toaster after using it to light a cigarette. The policy incorporated an approach aimed at offering "two good choices" so that the girl always had positive alternatives and the opportunity to exercise some self-control. The policy usefully spelt out permitted forms of sanctions which consisted of withholding pocket money to compensate for loss or damage, additional chores, withdrawal of privileges or activities, removal of possessions, removal from group and amending a girl's routine.

However, in practice, the mainstay of the unit's sanctions policy was a points system for rewarding good behaviour. Girls earned up to 60 points in the morning, 40 points in the afternoon/evening, a bonus of 20 points for not smoking and a bonus of 10 points for achieving a maximum. The points attained equated to pocket money (i.e., 1pt = 1p). Staff saw it as a way of measuring girls' behaviour and some of them had come to rely upon it as the central method of control.

Gleann Alainn applies other methods of control, but these are not part of the unit's sanctions policy.

ADDITIONAL METHODS OF CONTROL

Gleann Alainn exceptionally placed girls in the isolation room. Unit managers stated that this was very rarely used and only for extremely violent behaviour. When a girl is placed in the isolation room she is never left on her own and the unit's GP is contacted if a girl is in the isolation room for more than one hour or more than three hours in any 24 hour period. An experienced member of staff informed inspectors that the isolation room had never been used in the last three years, but when it was, there was a required policy that this was recorded.

The quiet room was used more frequently for girls who are disturbed or out of control, but whose behaviour did not constitute a threat. The unit made a record of each occasion that a girl was placed in the quiet room, on a form specifically devised for the purpose.

It was also an exceptional event that required all of the girls to be locked in their rooms. This could occur if exceptionally there was rioting or an assault on staff. Inspectors were told that there has only ever been one riot, which happened in October 1999.

3.9 Unauthorised absences

The centre takes steps to ensure that young people who absent themselves from the centre without consent are protected in line with written policy and guidance.

Gleann Alainn does not meet the requirements of this standard and must more consistently recognise its role in detaining the girls in its care. Levels of unauthorised absences from Gleann Alainn were on occasion unacceptably high, especially for a special care unit. Between the period 17 February 1999 and 31 January 2000 there were twenty-eight incidents of unauthorised absences.[3] Two girls had each run away three times, two other girls had each gone missing four times and two other girls had each been absent on seven separate occasions. The shortest period that a girl had been absent for was forty minutes, whilst the longest unauthorised absence was seventy-nine days.[4] This was not a typical pattern of unauthorised absences as many girls were missing for no more than a few days and most for only a matter of hours. Statistics also showed that on nearly half of all occasions that girls ran away they returned to the unit of their own volition. Staff explained that some of the

[3] Inspectors were informed that rates of unauthorised absences had been higher in previous years.
[4] This did not include two girls who ran away and had not returned.

unauthorised absences occurred whilst girls were engaged in activities or visits outside of the unit. Statistically, this accounted for less than 3% of all such absences. There was limited evidence of girls putting themselves or others at risk of harm whilst absent and most were missing for short periods of time. Staff, social workers and managers regarded the act of unauthorised absence as involving risk to the young person. Inspectors heard that one 15-year-old girl had high levels of absenteeism and staff were particularly concerned about the risks associated with this. Whilst Gleann Alainn should be encouraged to permit girls opportunities to go outside of the unit, such critical decisions ought to be backed up by a proper and transparent process of assessment. Gleann Alainn needed to show that it had given due regard to potential risk and determined a course of action based upon the girl's needs and welfare. The practice of gradually testing out each girl's ability to cope with greater freedoms was essential to Gleann Alainn's core purpose of preparing them for moving on to a more open setting.

The unit relied on outside activities and needed to re-evaluate whether this was because there were insufficient things for girls to do within the unit. This reliance often conflicted with proper regard for security considerations and a better balance of activities within the unit was needed.

Gleann Alainn had a written policy which provided guidelines on the prevention of absences, how staff should deal with attempted running away, how staff are required to act if a girl runs away whilst outside the unit, procedures to be followed after an unauthorised absence and procedures following return from a period of a girl being missing. Upon their return girls were given a full admissions search. They were also interviewed after returning so that staff could establish if there were particular reasons for their running away.

When girls ran away Gardai were notified. Staff also went out to look for absent girls, if they had a reasonable idea as to their whereabouts, to encourage them to return. There was evidence that they had some successes in this. The unit manager gave one example of meeting a girl, who had absconded and was persuaded to return to the unit voluntarily. Considerable efforts were made to encourage girls who went missing to return. Inspectors observed an occasion where the unit manager and one of the care staff returned one girl who had gone home without permission. They also permitted the girl's mother to return with her, which inspectors commend as this helped the girl settle back into the unit.

RECOMMENDATIONS

19. Managers should conduct an urgent review of security and develop a plan to reduce levels of unauthorised absences.

20. Gleann Alainn should introduce a formal assessment process to assist in determining when each girl is ready to experience greater liberty.

3.10 Ethos and quality of care

3.10.1 *Living skills*

The acquisition of living skills is an integral part of the care process and should be individually tailored to meet the needs of each child in a structured and planned way. The care experience provides children with the skills, competencies and knowledge necessary for adulthood and citizenship.

Girls acquired and internalised a set of living skills whilst at Gleann Alainn. Whilst some of this was inevitably geared towards institutional compliance, inspectors saw evidence that staff helped girls with their personal development. Gleann Alainn placed considerable emphasis on promoting girls' self-esteem, developing coping skills, relationship forming and accepting levels of individual responsibility. These helped prepare each girl for moving on from Gleann Alainn. The unit provided a broad range of experiences for the girls, many of which were part of a planned and structured programme.

Gleann Alainn provided the girls with a broad range of activities and interests. These included tennis, basketball, swimming, cinema, horse riding, athletics and aerobics. The girls had been taken hostelling and hill walking. Permission for trips out was left to unit discretion, but procedure required the consent of the girl's social worker if overnights were involved. There was no separate requirement to seek the authority of the High Court. The benefits of providing the girls with outside, supervised, activities needs to be balanced against the increased opportunity for them to run away. These activities provide an important source of evidence as to whether particular girls are ready to move on from secure detention and thus form an important element in enabling professionals to assess and monitor risk. Statistical evidence, relating to the number of unauthorised absences, indicates that professionals have not been consistently getting the balance right.

Staff suggested that a unit vehicle might help them improve the level and variety of outside activities. Both the child care manager and general manager told inspectors that the acquisition of a unit vehicle was under active consideration.

There were a number of board games and arts/craft materials which were used for indoor recreation. The girls did some cooking and inspectors sampled some of what they had produced. Inspectors heard from staff and girls alike

that life in the unit could be boring and overcoming this represents a real and constant challenge. Staff stated that the availability of more outside space would be helpful. Inspectors consider that more attention needs to be given to improving the quality and choice of indoor activities.

An occasion was made of special days for the girls, especially birthdays (cakes, cards, trips out etc). Gleann Alainn, where possible, tries to include family in these.

Inspectors were told that staff and girls shared cleaning and laundry chores.

Girls go out accompanied by staff to purchase their own clothing. They usually used vouchers instead of cash to pay for goods and this makes the girl's experience of budgeting less real. Exceptionally, they bought from other shops with cash, which needed to be obtained in advance. Petty cash sets limits on what can be paid for this way.

RECOMMENDATION

21. Gleann Alainn should introduce a wider range of in-house activities commensurate with the girls' interests.

3.10.2 *Psychological and emotional development*

The emotional life of young people in care is given special attention. Young people know that there is a responsible adult available who is capable of understanding them, and as such, is a real source of confidence and support for them.

The emotional life of girls in the unit was given special attention and Gleann Alainn operated a key-worker system to ensure that their particular needs were addressed. Two key workers were assigned to each girl and their duties were usefully spelt out in the policies and procedures booklet.

There was a consultant psychologist attached to the unit and this provided a valued service. He offered professional support and advice to the unit, as well as working directly with the girls. Whilst Gleann Alainn was clearly well-resourced, the board regarded itself as being poorly resourced in the area of psychological services and managers felt that 16-18 year olds often fell between child psychiatry or adult services. Sometimes the girls have had to access adult services. Most of the girls admitted to the unit required therapeutic help and it was noted that such help was available. The unit had access to a consultant psychologist who undertook some direct work with the girls and also provided professional support and advice for the staff. Some individual work was being done on anger management and there were groupwork sessions on behaviour management.

The unit had both behaviourist and cognitive models operating concurrently. One of these was grounded in techniques of behaviour modification and manifested through the operation of a points based token economy system.

The other utilised methods of psychotherapy and was more focused upon helping girls to accept greater levels of personal responsibility through contextualising and exploring reasons for their behaviour. The unit placed great emphasis upon psychological theories of "containment" in which girls developed and internalised better coping skills. Inspectors consider that staff would benefit from receiving appropriate therapeutic training to ensure that these methods are being applied properly. Staff must be appropriately trained and competent in any therapeutic intervention that they use.

One girl raised issues of injustice because she had committed no offences and was locked up whereas those who had offended against her still enjoyed their liberty. She does not think that the way she had been treated is right. It is probable that many girls placed at Gleann Alainn will have internalised strong feelings of injustice and inspectors believe that their concerns about civil liberties matters must be addressed. Few of the girls in Gleann Alainn have committed offences and many have been victims. Some consider that restricting their liberty is unjustified and have internalised anger which make it more difficult for them to initially accept the help that staff offer.

RECOMMENDATION

22. All staff should understand the purpose of the therapeutic interventions being used and be capable of evaluating their effectiveness and utility. Staff need access to appropriate training in the therapies and methods that they are using with the girls.

3.10.3 *Preparation for leaving care*

Young people are adequately prepared for when they leave care, equipped with the skills, knowledge and resources which they will require.

Gleann Alainn did not have any written procedures relating to preparation for leaving the unit and inspectors regard this as an oversight. In practice preparation for leaving was good but not well co-ordinated. Inspectors heard consistently, from residential child care and social work staff, that girls were ready to leave Gleann Alainn but were stuck there mainly for the want of an available 'open' placement. The planning for girls leaving should be as precise and detailed as for admissions. Ideally, each girl should be given a realistic indication of how long her liberty is likely to be restricted. In general, the period of restriction of a person's liberty should be limited to the shortest possible time necessary. It should be determined by assessed individual need and kept under regular review. A girl should not have to spend longer than

necessary in secure conditions for the want of appropriate alternative care arrangements in the community. It was encouraging, therefore, to note that girls at Gleann Alainn can have access to a 'step down' unit, in preparation for moving on. Lough Mahon was opened in January 2000, is a three-bedded facility and had three girls in residence. Two had previously been in Gleann Alainn.

A working party had been set up to consider the need for leaving care services. The need for leaving care services should be incorporated into a Board-wide childcare strategy, and a recent Southern Health Board section 8 'adequacy' report provided evidence for this. They plan developing local in-care and aftercare groups as a way of giving girls a voice and providing them with a better support structure to enable them to cope with independent living.

Analysis of the time spent by girls in Gleann Alainn, based upon the last twelve discharged, revealed that six girls had been there for about six months whilst a second cohort of five girls had been detained for over a year. The other girl was at Gleann Alainn for five weeks. Gleann Alainn might want to study these patterns to see if there are any particular factors that explain why some girls are detained for appreciably longer than others. A more in depth look at these cases might provide an indication of the numbers of girls who are detained longer than necessary awaiting of suitable support services in the community.

RECOMMENDATIONS

23. Gleann Alainn should develop a written procedure outlining how girls, as appropriate, should be prepared for leaving care from the unit.

24. The Board should ensure that there are effective systems in place to support girls moving on from Gleann Alainn. These need to be closely integrated with the admissions, planning and review process and be capable of giving each girl a reasonable indication of how long they are likely to be kept in secure conditions.

3.10.4 *Physical aspects of the residential centre*

Young people experience their living environment as similar in terms of furnishings and facilities to the homes of their peers.

Inspectors feel that Gleann Alainn does not meet this standard at present, but were satisfied with written assurances that the décor and furnishings are being upgraded. The unit was located within a hospital complex, which contributes towards its institutional appearance. Obviously, there was little that the unit could do about where it was situated. However, there was considerable scope

for improving the look of the actual building and its interior. The bedrooms were sparsely furnished and the unit, as a whole, lacks posters, plants, curtains, carpeting and ornaments, which would create a more homely and welcoming atmosphere. Without improvements girls will continue to experience a living environment more akin to a penal establishment. Gleann Alainn should give this urgent attention if they are to convince girls that the unit's main purpose is not to punish them.

A letter sent to the social services inspectorate from the unit manager identified the renovations that are currently in hand. These consist of the following;

" New unbreakable light fittings (including emergency light fittings) throughout which will obviate the necessity for the wire meshing presently surrounding the light fittings.*

** All areas which the children have access to will have the conduit chased into the ceilings and walls.*

** New wool carpets throughout.*

** All the children's bedrooms are being upgraded. This will include; low level windows, built-in wardrobes, electrical sockets, light switches, new doors with side viewing panels with curtain/blind for privacy, new curtains and carpets. Each child will have a key to their own bedroom and a master key system will operate for staff access (the possibility of new beds is also being considered).*

** The development of a sensory garden at rear and landscaping to the front. The outdoor games area to be enhanced.*

** The inclusion of an art cum games room, a music room which will double as a visitor's room.*

** Refurbishment of staff bedrooms, which will be inclusive of ensuites. One of these ensuites will be accessible to people with disabilities.*

** New kitchen with beech wood effect featuring a fitted kitchen with integrated appliances.*

** Additional shower and upgrading of the existing showers.*

** The entire unit (inside and out) is being repainted and safe decorative accessories i.e. pictures, mirrors, plants etc. are to be added to the décor."*

Inspectors hope that these plans will not only enhance the look of the unit, but also crucially how girls experience their care within in it.

RECOMMENDATION

25. Plans to upgrade the appearance of the unit should be completed as soon as possible.

3.10.5 *Respect of child's privacy, dignity and individuality*

The unique worth and individuality of each child should be valued and reflected in the ethos, management and care practices of each centre. Children's quality of life will be influenced by the value placed on their dignity and individuality in all aspects of daily living.

Gleann Alainn had a written policy which emphasised the importance of respecting each girl's privacy.

The unit provided a 'quiet room', which was used for family visits affording girls and their visitors a measure of privacy. However, its use should be placed within the context that the quiet room also functioned as a room for girls who are in need of control and require separating. Visits were generally private, but can be supervised if this is specified or necessary for reasons of security. Friends, including boyfriends, had been able to visit. Girls made and received telephone calls, but staff answered all incoming calls and dialed out. Girls were able to phone their social worker, solicitors, family (unless restricted or supervised) and appropriate friends. Calls were taken in the computer room and following staff's initial screening were held privately. Girls must open letters in front of staff, although inspectors heard of one exception when a girl was trusted to open her own letter from her boyfriend in private. Staff did not generally read letters written by girls, but will check who they are being sent to. Teachers were looking into e-mail communication and policy on the safe use of the internet is being developed. Inspectors supported this initiative, as it would help promote the girls contact with the outside world. Gleann Alainn did its best to promote respect and sensitivity for girl's privacy. It did not allow security to frustrate putting this aspect of its policy into practice and, in this respect inspectors consider that the standard to be met.

Other aspects of practice in the unit could stand improvement. Girls did not keep their own sanitary protection and indicated to inspectors that it was embarrassing having to ask staff for these. Staff said that girls could keep them if they wished, but had never been asked. They confirmed that girls would never be required to ask male staff. Inspectors consider that staff could permit girls to keep their own sanitary protection and ensure that there are arrangements for their safe storage within their own bedrooms.

Security inevitably impacts upon the lives of girls in the unit. They were subjected to full searches. These are carried out where clothes are checked

and the girls are required, whilst wearing a loose nightgown, to walk up and down to satisfy staff that nothing has been concealed. Girls undress for searches in private. Girls told inspectors that whilst they did not like being searched these were conducted in a way that preserved their dignity. These were distinguished from "pat" searches. Staff told inspectors that security checks of bedrooms used to be nightly but now only took place when there were staff concerns about security. Girls usually were told about these in advance. Staff said that they received no special training on pat searches, but knew that these must be done if any of the girls were self-harming. Use of searches was subject to detailed written guidelines setting out the policy, indicating when searches should be carried out, what to do in the event of a girl refusing to be searched, and the search method that should be used. Staff were required to seek consent from girls in the first instance and it was policy that a record of all searches was made. In all incidents of searches male staff were kept out of the way.

The girls were required to dress/undress in the communal bathroom because their own bedrooms have viewing panels. Obviously security cannot be compromised, but inspectors consider that the unit needs to find an approach more balanced with regards to the dignity and individuality of the girls. They were permitted to go into each other's bedrooms for a chat, subject to the requirements of security.

Bedroom doors were alarmed at night and were activated if opened. Night staff also monitored the girls throughout the night at intervals determined by the requirements of security. Whilst this inevitably impacted upon the girl's need for privacy inspectors understand that these arrangements were necessary.

RECOMMENDATION

26. Gleann Alainn should ensure that girls have private changing areas and are able to keep their own supply of sanitary protectors.

3.10.6 *Preserving the child's sense of identity*

Residential care should contribute to the development of a positive sense of self. Respect for and the accommodation of cultural, religious, ethnic and family background of the child are crucial to the formation of an integrated identity.

Gleann Alainn's whole approach emphasised promoting the self-esteem of girls in the unit. They were attempting to do this from a starting point where most of the girls did not have a high regard for themselves. The image that girls had about themselves was partly influenced by their being in conditions of security. Considerable care must be taken to ensure that their placement and status in a secure setting does not contribute to this further.

Girls were encouraged to go to mass and inspectors heard from a social worker that one girl was recently sanctioned for not going. There were professional differences on this question and the High Court was being consulted about its role, under wardship jurisdiction, in the determination.

The girl's background was respected and families were encouraged to play an active role in providing them with a sense of their own identity.

3.10.7 *Education*

Each child has a right to education, which should be seen as a significant issue affecting the welfare of the child. The residential setting should be one in which education is valued, children's educational needs are actively addressed and each child is encouraged to attain his/her full potential. This will involve liaison with the health board social worker, schools and other appropriate training and educational bodies.

Gleann Alainn has its own education unit on site, which four out of the current group of five girls attend. Existing teaching resources consisted of a full-time, temporary teacher in charge and three part-time, temporary teachers; each appointed by the Vocational Educational Committee through existing Department of Education and Science funding. Additionally, there was a support teacher appointed by the Board. There was an art teacher who contributes 3 ½ hours per week, a home economics teacher who did 5 ½ hours per week, a science, personal and social education teacher working 4 hours per week and the support teacher who offered 4 ½ hours per week. The school timetable ran from 9:20am to 3:30pm and the curriculum covered subjects of maths, English, Irish, history, geography, home economics, science, personal and social development, information technology, art and games. There was one classroom allocated and a computer room which the teacher in charge was hoping to make it into a second classroom. The teacher in charge emphasised the need for equipment that was specifically for the teaching department (e.g. computer). However, a resource such as a computer will also have benefits for girls' leisure time and recreational activities and inspectors feel that this needs to be taken into account.

The draft development plan (1999-2004) sets out in detail main priorities, key targets and action timescales in relation to management, curriculum development and individual learning needs.

The teacher in charge outlined, for the benefit of this inspection, five problem areas and possible solutions to these. First, he highlighted that Gleann Alainn's education unit did not have permanent status, causing difficulties in staffing and forward planning. The teacher in charge feels that there was a need to create a permanent education unit. Second, the teacher in charge raised concerns that insufficient consideration was given in the admissions process to integrating girls into the education unit, particularly in respect of the

timing of this. He said that this contributed to inappropriate groupings and a dissipation of teaching focus, provision and resources. He suggested that his, or other vocational education committee officer's, involvement in the planning of admissions would help them to better consider the needs of both the current cohort and new admissions. Inspectors noted that teachers were included as part of the case management team and it would be helpful for education specialists to have an input into the admissions process. Third, the teacher in charge said that there was a need for girls admitted to Gleann Alainn to receive an initial educational assessment. Fourth, the teacher in charge said the education unit was under-resourced which restricts the variety and appropriateness of education provided. He believes that there should be an education budget allocated, under the control of the teacher in charge. Inspectors agree that education at Gleann Alainn should be properly resourced and that the teacher in charge ought to have some say in how these are managed. Fifth, the teacher in charge made the point that the impending increase in numbers of girls, from five at present to seven, will require a corresponding increase in teaching staff.

Working relationships between teaching and residential care staff were occasionally strained. This was perhaps a reflection that the education and residential units were insufficiently integrated. Inspectors believe that communication between teaching and care staff could be improved.

The girls' ages and levels varied, some going up to junior and leaving certificate. Gleann Alainn said that they had some very bright girls with potential to convert this into academic successes given the opportunity, resources and encouragement. Considerable efforts were being made to support girls' educational needs. Girls admitted to the unit had experienced considerable gaps in their educational careers to date or had specific learning needs. The education provided at Gleann Alainn did much to address these.

One girl attends outside primary school and that is thought to working out very well and meeting her educational needs.

RECOMMENDATION

27. Managers should ensure that the education unit is fully integrated, so that it complements the other functions carried on in Gleann Alainn.

3.10.8 *Health care*

The provision of appropriate health care and advice is acknowledged as an essential element in the arrangements for the care of young people in the centre.

Girls in the unit appeared to be in good health and having their medical needs met. Gleann Alainn had its own doctor for the unit. Staff told inspectors that the girls were not always happy with the fact that the unit's doctor is a man, but say that there was not anything that can be done about it. The unit manager said that they had unsuccessfully explored possibilities of being allocated a female doctor. She assured inspectors that a female doctor could be brought in on occasions if a girl insisted, but this had proved to be very difficult in practice. The lack of access to a female doctor was seen as a gap, although the unit's existing doctor was otherwise regarded as very suitable.

Inspectors were told that girls undergo a medical examination upon admission to the unit and were satisfied that this met the requirements laid down in Article 20 of the Child Care Regulations 1995. Records provided evidence for this. Pregnancy tests were done on admission and upon return from unauthorised absences. A doctor was called and urine samples were sometimes taken for toxicology tests. Social worker consent was required for this.

Inspectors discovered that medication was on one occasion used in order to control a girl's behaviour, but were assured by the unit manager that this had been done only under strict medical supervision and involved an increase in medication already prescribed.

RECOMMENDATION

28. Efforts should continue in trying to secure the availability of a female doctor.

3.10.9 *Pets*

The keeping and choice of pets in the centre can contribute towards promoting the welfare of young people and help instil a keen sense of responsibility.

The unit did not have a pet but were giving active consideration to the idea. Inspectors heard that the staff group were not entirely in agreement about what type of animal makes the best pet. Inspectors view was that a pet for the unit

would be an excellent addition to promoting responsibility amongst the girls, whilst contributing towards creating a caring environment.

3.11 Administration

3.11.1 *Fire precautions*

The centre takes positive steps to keep children safe from the inherent risk of fire and other hazards to an extent that is consistent with Regulation 12 of the Child Care Regulations, 1995.

Inspectors were satisfied that this standard was being met. The unit maintained a comprehensive and detailed fire safety register that includes codes of practice, guidance for completion of fire safety register, specific fire duties assigned to particular staff members and completed pro-forma for;

1: fire evacuation drills (24/8/98 & 21/3/00),
2: annual inventory of fire fighting equipment,
3: location of fire fighting equipment,
4: monthly inspections of fire fighting equipment,
5: annual maintenance of fire fighting equipment, emergency lights and certificates of inspection.

The unit had a system of allocating key checking tasks to named staff. Inspectors were able to verify, from records kept, that emergency lighting was last inspected on 21/3/2000 & 10/4/2000, the fire alarm system was last tested on 10/4/2000, the fire resisting doors/exit doors were last checked on 10/4/2000 and upholstered seating and furniture was last checked on 10/4/2000. Inspectors noted that all records were dated and signed.

The unit had an inventory of fire fighting equipment, which consists of;

1 x water extinguisher (staff office)
4 x foam extinguisher (2 x staff office, 1 x managers office, 1 x store room)
4 x CO2 extinguisher (2 x store room, 1 x staff office, 1 x managers office)
1 x hose reel
2 x fire blankets (1 in kitchen / 1 in classroom)

In accordance with unit procedure these were last inspected on 21/3/2000. Inspectors were satisfied that the above equipment was present and had been recently tested.

3.11.2 *Insurance*

Each children's residential centre should be adequately insured against accidents or injury to children placed in the centre.

Gleann Alainn was adequately insured under the Board's cover against personal and public liability. This was sufficiently comprehensive to include insurance against all accidents and injuries to girls in the unit. Inspectors were satisfied with insurance arrangements covering members of staff who may be required to transport a girl in a privately owned vehicle. However, the board may need to satisfy itself that any vehicles used for this purpose are kept in roadworthy condition.

RECOMMENDATION

29. The Board should satisfy itself that private vehicles used by its employees to convey girls are maintained in a safe and roadworthy condition.

3.11.3 *Young people's records*

Each young person has a permanent, private and secure record of their history and progress which may, where in compliance with legal requirements for safeguards, be seen by the young person and by the young person's parents as appropriate.

Girl's files were reasonably well maintained, containing copies of legal orders, detailed applications, the placement plan, a range of reports from various professionals (e.g. teachers, psychologists, psychiatrists and care workers from previous placements), weekly key worker reports, review reports and flowcharts illustrating each girl's moves whilst in care. Only two files contained completed care plans, one of which was in draft form attached to the placement plan and care workers in the girl's previous placement had drawn up the other. Girl's personal files also contained completed forms showing uses of physical restraint, life space interviews, sanctions and girl's removal to the quiet room. Impressively, they all contained a copy of a letter sent to each girl's parent/s enclosing a copy of Gleann Alainn's policies and procedures document.

However, inspectors did find room for improvement. Deficiencies that were identified include failure to provide a frontsheet setting out basic information, although the unit operates a card indexing system which contains this. No birth certificates were found. The files possessed few educational and medical records, even though there were sections provided for these. Files did not consistently provide a record of visits by family or social workers. Without

intending to detract from the excellent work done in constructing placement plans, some files do not have proper, completed care plans. Inspectors advise that attention is given to rectifying this position.

One social worker said that she was not sure if Gleann Alainn files contain the same information as is kept on department case files. For example, the social worker stated that her understanding was that the original birth certificate should be kept on departmental files whereas the unit would be expected to have a photocopy. This evidence lead inspectors to conclude that files could be better harmonised to ensure that all professionals know what information is held about girls at Gleann Alainn, where this information is kept, how it can be accessed and for what purpose records have been made. Inspectors also found that girls experience very limited access to the contents of their personal files.

Gleann Alainn's policies and procedures did not specifically refer to the maintenance of files, although staff were supported in this task by having a clear written statement of the unit's policy on confidentiality. Inspectors believe that the unit should develop a policy on the keeping of girls' files in line with existing Board policy, the requirements of freedom of information legislation and this reports comments concerning access to information (see 3.6.3). This policy should be supported by procedures which set out how applications for access to files will be considered.

RECOMMENDATIONS

30. Girl's files kept at 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.

31. Gleann Alainn should issue written guidance to staff about maintaining files.

3.11.4 Administrative records

Administrative records contain all significant information, decisions and actions relevant to the effective running of the centre.

Inspectors found Gleann Alainn have good administrative records. Its policies and procedures manual set out extensive guidance to care staff on what records were required and how these should be kept. These include the regular maintenance of a unit log book, individual report notes, incident sheets, visitors book and office diary each of which contribute towards a good flow of communication. In addition, the unit keeps a petty cash book, a separate sanctions book and, a fire and safety log book. Inspectors saw plenty

of documented evidence that record keeping is thorough and provides relevant information for the efficient running of the unit.

3.11.5 *Safety*

Each children's residential centre has adequate arrangements in existence to guard against the risk of injury occurring on the premises, in accordance with Article 13 of the Child Care Regulations, 1995.

Gleann Alainn provided girls with a safe environment. Safety issues form an important aspect of work in the unit and were addressed in conjunction with the need to maintain high levels of security. Staff exercise great caution in these matters and effective monitoring systems were in place. This contributed to reducing the potential for injury or self-harming on the premises. The unit specifically operated with safety in mind. Gleann Alainn met the requirements of the standard and had written policies in place on staff safety. These provided for;

- all new staff to be inducted in matters of personal safety,
- management to be advised of potentially dangerous situations requiring extra staff,
- a reasonable level of security,
- training in the use of therapeutic crisis intervention,
- staff to exercise vigilance in respect of their own safety and that of colleagues,
- advice cautioning staff to avoid being alone with any of the girls,
- staff to carry personal attack alarms at all times,
- advice to staff on the availability of vaccination against hepatitis B, and
- advice to staff that relaxation exercises must take place in easily observable areas and in the presence of other colleagues.

Inspectors noted that the unit had a health and safety policy statement, dated from 1999 and were satisfied that this was being carried out in practice.

3.11.6 *Maintenance of register*

Information on individual children who are admitted to a residential care centre is recorded in a Register, maintained by a health board, under Section 21, Part iv of the Child Care (Placement of children in Residential Care) Regulations 1995. Such information is updated as changes occur and includes information on the circumstances and the date on which a child is discharged.

Inspectors were advised that a specific register of girls admitted to Gleann Alainn was not currently maintained there, but was incorporated into records retained in the child care manager's offices located in Abbeycourt House. Other recording systems allowed the unit to furnish inspectors with precise details about girls who have resided there, together with their movements since.

RECOMMENDATION

32. A discrete register showing admissions to and discharges from the unit should be established and kept in the unit.

3.11.7 *Supervision and visiting of young people*

A young person who has been placed in a centre by a health board is visited by an authorised person as often as the board considers necessary, having regard to the care plan prepared for the young person and any review of this plan, but in any event at intervals not exceeding those specified by Article 24 of the Child Care Regulations 1995.

This standard is well met. Inspectors discovered from interviewing social workers that they made frequent visits to the unit, which occurred on average about once per fortnight. This was reinforced by the regularity of monthly review meetings held on girls in the unit and Gleann Alainn itself took considerable credit for setting these as its expectations for social work support. Inspectors were informed that the unit had adopted this practice in recognition of the seriousness involved in depriving any girl of her liberty. It was a practice which inspectors fully endorse.

Inspectors were disappointed that proper records of social worker's visits were not kept.

3.12 Management

3.12.1 Centre management

The centre is properly managed and staff are organised and deployed in a way that enables the centre to operate effectively and efficiently to the required standard.

Inspectors regard the unit as reasonably well managed, but leadership must direct staff efforts to reducing the incidence of unauthorised absences. The unit could not function effectively, or in accordance with expectations of its main purpose, until it ensured that girls were more consistently kept in a secure and controlled environment. Staff were provided with detailed written guidance about their role and there is a clear sense of purpose about what the unit was aspiring to achieve. The unit manager was responsible for the work of all care staff at Gleann Alainn. The acting deputy unit manager supported her in this task and together they sought to promote an inclusive management style. Staff contributed towards aspects of management through the forum of team meetings, group supervision, team development days and by rotating responsibility for acting as shift co-ordinators. Consideration was being given to reverting to the appointment of team leaders, providing recognition for the role and opportunities for staff progression within the unit.

The teacher in charge separately managed the teaching staff, which was satisfactory for matters relating to the educational needs of the unit.

3.12.2 Health board management

The Health Board provides each centre with the support required to promote and maintain quality standards.

The Board provided good management support to the unit. The child care manager was the immediate line manager and, in conjunction with Gleann Alainn's consultant psychologist, offered supervision and professional advice to the unit manager. The child care manager in turn reported to the general manager, who took an active interest in the work and development of the unit. Inspectors were informed that the Board were considering strengthening management arrangements with the appointment of a fifth child care manager for the area, with a specialist residential child care brief. The child care manager spoke in terms of Gleann Alainn doing great work, and credited the commitment of a number of individuals. The child care manager emphasised that Gleann Alainn had been a considerable learning experience for the board and initially there was not enough consideration given to how would it fit into overall child care services. Plans were now in place to increase the number of

beds at Gleann Alainn from five to seven and the building work associated with this was underway. Managers were also implementing plans to provide a special care facility for boys and, of particular utility to Gleann Alainn, had already opened a "step-down" unit that will help expedite girls moving on.

Gleann Alainn was able to benefit from management that was informed by current thinking and changes being introduced through the passage of the Child Care Bill 1999. The involvement of the child care manager and the unit manager in policy development work at a national level supported this view.

3.12.3 Monitoring of standards

The centre has adequate arrangements in place to enable an authorised person, on behalf of the health board, to enter and inspect the centre in compliance with Article 17 of the Child Care Regulations, 1995.

Arrangements for monitoring the work of the unit did not satisfy the requirements of either the standard or Article 17 of the Child Care Regulations 1995. This function needs to be properly clarified and assigned to a named 'authorised person'. Inspectors recommend that the Board specify the frequency with which the 'authorised person' should enter and inspect the unit. Written reports should accompany the visits made and these should demonstrate how the unit is complying with Articles 5 to 16 of the Child Care Regulations, and what action is required to ensure proper compliance.

RECOMMENDATIONS

33. The Board should put in place arrangements for monitoring Gleann Alainn in accordance with Article 17 of the Child Care Regulations 1995.

34. Management should, in addition to the requirements set down in the regulations, monitor the use of physical restraint and incidence of unauthorised absences.

3.12 Physical restraint

Physical restraint is never used as a punishment, but only to protect from immediate risk of injury or serious damage to property. The Health Board has a policy on the use of physical restraint that is clearly understood by all staff and young people in the centre.

Gleann Alainn provided detailed practice guidelines to its staff on use of physical restraint. This emphasised therapeutic crisis intervention as the only permitted method of restraint and set out measures in place to ensure proper professional accountability. These included clear reporting arrangements and ensuring that all incidents involving use of physical restraint are reviewed. Inspectors regard Gleann Alainn as having a good and comprehensive policy on the use of physical restraint. Documented evidence shows that use of physical restraint is being recorded appropriately and provides corroboration that 'life space interviews' are practiced as an integral part of deploying therapeutic crisis intervention. Inspectors heard from staff that there was a policy of not restraining girls outside of the unit, but did not find any written evidence to support this.

Staff, managers and social workers told inspectors that in practice use of physical restraints are relatively infrequent at Gleann Alainn, although one parent contradicted this and suggested that her daughter was constantly being physically restrained. Of the current residents, one girl had not been physically restrained, whilst two girls had each been restrained once in the space of a month. Two other girls had been restrained six times each over a nine month and eleven month period respectively. Whilst inspectors concluded that the frequency of restraints should be regularly monitored, the findings did not tend to support the parent's impression.

4. Summary of recommendations

1. **The unit should ensure that its statement is more explicit in defining that its purpose is for girls and one of its functions is to restrict their liberty.**

2. **The unit should clarify its therapeutic function.**

3. **Gleann Alainn should progress work on upgrading the physical appearance of the building as this will contribute towards making the unit a more welcoming place to be admitted to.**

4. **Gleann Alainn should explore ways of finding a better balance between routine security procedures and the need to be welcoming.**

5. **All girls admitted to Gleann Alainn should have access to separate legal representation, regardless of which board seeks to have them placed there. The Southern Health Board should develop protocols with other placing boards to ensure that this happens.**

6. **The Board should ensure that written care plans are being produced in line with the requirements of Article 23 of the Child Care Regulations 1995. These should augment work being done on placement plans and where practicable be in place prior to admission.**

7. **The development of care plans should be informed by a multidisciplinary assessment of each girl's needs.**

8. **Girls should be permitted to attend as much of their care review meetings as is practicable.**

9. **Girls and parents should routinely receive copies of minutes from care review meetings.**

10. **There should be no distinction in the status of care review meetings. Each should be a statutory review, regardless of how frequently they are held.**

11. **All three boards should explore practical ways of supporting family contact and be more explicit about how reasonable expenses incurred by them might be met.**

12. **The Board should ensure that an increased proportion of staff employed in Gleann Alainn hold, or be facilitated in acquiring, recognised qualifications in child care.**

13. **Staff should be provided with a formal programme of induction, supervision and ongoing training to best equip them for the tasks they are required to carry out.**

14. **These should happen frequently and inspectors recommend that the unit undertake an audit of staff training needs as a precursor to drawing up a training action plan.**

15. **Individual supervision should be regular and guaranteed.**

16. **Gleann Alainn, in conjunction with social workers and management, should draft a policy statement setting out how they propose to seek girls' views, and ensure that they are given due consideration.**

17. **Managers should consider how they propose to resolve the lack of confidence that girls and staff have in the complaints procedure.**

18. **Managers should revisit their approach to handling complaints to ensure that procedures are sufficiently credible to contribute useful management information about girls' dissatisfaction with the service they receive.**

19. **The board should develop a policy on access to information in line with the requirements of freedom of information legislation. This should set out how requests for access to personal files will be handled and encourage staff to routinely share written records with the girls.**

20. **Managers should conduct an urgent review of security and develop a plan to reduce levels of unauthorised absences.**

21. **Gleann Alainn should introduce a formal assessment process to assist in determining when each girl is ready to experience greater liberty.**

22. **Gleann Alainn should introduce a wider range of in-house activities commensurate with the girls' interests.**

23. **All staff should understand the purpose of the therapeutic interventions being used and be capable of evaluating their effectiveness and utility. Staff need access to appropriate training in the therapies that they are using with the girls.**

24. **Gleann Alainn should develop a written procedure outlining how girls, as appropriate, should be prepared for leaving care from the unit.**

25. **The Board should ensure that there are effective systems in place to support girls moving on from Gleann Alainn. These need to be closely integrated with the admissions, planning and review process and be capable of giving each girl a reasonable indication of how long the are likely to be kept in secure conditions.**

26. **Plans to upgrade the appearance of the unit should be completed as soon as possible.**

27. **Gleann Alainn should ensure that girls have private changing areas and are able to keep their own supply of sanitary protectors.**

28. **Managers should ensure that the education unit is fully integrated, so that it complements the other functions carried on in Gleann Alainn.**

29. **Efforts should continue in trying to secure the availability of a female doctor.**

30. The Board should satisfy itself that private vehicles used by its employees to convey girls are maintained in a safe and roadworthy condition.

31. Girl's files kept at 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.

32. Gleann Alainn should issue written guidance to staff about maintaining files.

33. A discrete register showing admissions to and discharges from the unit should be established and kept in the unit.

34. The Board should put in place arrangements for monitoring Gleann Alainn in accordance with Article 17 of the Child Care Regulations 1995.

35. Management should, in addition to the requirements set down in the regulations, monitor the use of physical restraint and incidence of unauthorised absences.

5. Executive summary

1. Gleann Alainn is a special care unit located in Glanmire on the outskirts of Cork. It is situated in the grounds of a hospital and the building has been adapted for its purpose. The unit accommodates five girls aged between 12 and 16 years, who require to be detained on the authority of the High (or Circuit) Court.

2. Gleann Alainn has developed an impressive set of policies and procedures. These are well supported by high standards of record keeping. Staff are familiar with these and generally carry them out in practice.

3. Team spirit was very good and Gleann Alainn had developed bold and imaginative approaches to supporting its staff group.

4. Gleann Alainn showed a good general regard and caring for the girls.

5. Food in the unit was varied, plentiful, nutritious and prepared very well. Girls were offered a good selection.

6. There was a "step down" unit, enabling care planners to move young people on at a point when they are ready.

7. Gleann Alainn had access to the services of a consultant psychologist, who was attached to the unit.

8. Whilst it was commendable that girls get home leave and have access to outside activities, Gleann Alainn did not sufficiently get the balance of risk-taking right. There were at times high levels of absence amongst the girls. The frequency with which girls were permitted to be outside of the unit raised questions as to whether too many risks were being taken with their security or, indeed, whether some girls no longer needed to be detained.

9. Care plans were not consistently in place. However, placement plans drawn up by key-workers at Gleann Alainn represented a highly creditable piece of work.

10. Staff working within a special care environment need access to comprehensive and on-going training.

11. Some of the staff had concerns about the possibilities of allegations of abuse being made against them and this reflected in their practice.

12. The care planning process needed to be informed by an assessment of the girls' needs.

13. Inspectors were impressed at the frequency of social work visits and case reviews.

14. The location and appearance of the unit was bleak and uninviting. It was likely to stigmatise girls who are placed there.