Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Gleann Alainn Special Care Unit

in the Health Service Executive South

Inspection Report ID Number: 506

Fieldwork Dates: 18 and 19 October 2011
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Safer Better Care

About the Health Information and Quality Authority

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

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Social Services Inspectorate — Registration and inspection of residential homes for children, older people and people with disabilities. Inspecting children detention schools and foster care services.

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1. Introduction

The Health Information and Quality Authority's (the Authority) Social Services Inspectorate (SSI) carried out a full unannounced inspection of Gleann Alainn Special Care Unit (SCU) in the Health Service Executive South Region (HSE South), under *Section 69(2) of the Child Care Act, 1991*. This inspection was carried out by Bronagh Gibson (lead inspector) and Sharron Austin (co-inspector) between 18 and 19 October 2011. This is a report on the key findings of the inspection.

Special Care Units are inspected annually against the *Child Care (Special Care) Regulations 2004* and the *National Standards for Special Care (2001)*. The last full inspection took place in October 2010 and can be accessed on www.hiqa.ie as Report number 589. A follow-up inspection took place in March 2011 and can be accessed as Report number 593.

Following these previous inspections, and the publication of a National Overview Report in 2010 on the provision of special care services, the Authority required monthly progress updates on national recommendations which included two recommendations from the previous Gleann Alainn Inspection Report ID number 589. The HSE furnished the Authority with these progress reports up to the time of this inspection. However, although they outlined progress at a national level, they did not reflect the state of crisis Gleann Alainn was found to be in by inspectors.

Gleann Alainn has been a national resource since January 2007, and it has been managed by the National Manager for Special Care and High Support since January 2011. Prior to that, it was managed by the HSE North Lee Local Health Area, Cork (*see 1.2 Management structure)*.

The purpose of Gleann Alainn is to provide secure residential care for up to seven girls aged between 11 and 17 years on admission. The children are detained under High Court orders that provide for the liberty of a child to be restricted in order to secure their safety and welfare needs on the basis that they pose a serious risk to themselves or others.

At the time of the inspection, there were six children detained in the unit. Gleann Alainn also provided open accommodation in an apartment at the rear of the building for a seventh child, who was not detained, but was in the process of moving on to a community-based placement. This arrangement was not consistent with the unit's purpose and function and should not be repeated in the future.

The unit was located on the grounds of a hospital and was surrounded by a green area. There was a secure open area at the rear of the unit that was accessible to the children. One week prior to this inspection, the Authority was notified by the National Manager for Special Care and High Support that one child had taken a set of keys from a member of staff and she and another resident had absconded from the SCU in the early hours of the morning.

This was similar to a previous incident that had occurred in 2008, that had prompted an independent investigation and a review of safety and security measures in the unit. It was a matter of serious concern to inspectors such a serious breach of security should occur again. Inspectors were also notified prior to the inspection by an external professional associated with the case of one of the girls of concerns in relation to these absences and the delivery of care to that particular child.

Inspectors found that the unit was in a state of crisis and that this was due primarily to the poor standard of management which impacted negatively on the delivery of a good standard of care to the children, on the day-to-day practices of the staff, and on the capacity of the unit to fulfil its purpose and function.

The findings of the inspection were of such concern that straight after the inspection fieldwork the Authority requested immediate action by the unit's managers. These included:

- ensuring that line management and monitoring systems were robust, fully functioning and effective
- an assessment of risk and the development of safety plans specifically related to:
  - works being carried out on the unit,
  - missing unit keys and
  - the overall security of the unit
- the introduction of effective and accountable recording systems
- the implementation of the unit's supervision policy.

Inspectors were assured by the National Manager for Special Care and High Support that these actions were taken immediately after the inspection fieldwork as requested.

This report presents key findings under each of the four standards listed below, and it makes high level recommendations targeted specifically at the day-to-day operation of the unit and its management, both internal and external:

- Management and Monitoring
- Staffing
- Care of Young People
- Premises, Safety and Security.

Having considered the range and level of serious deficiencies found in the unit's compliance with the *Child Care (Special Care) Regulations 2004* and the *National Standards for Special Care (2001)* in the course of the inspection, it is the intention of the Authority to carry out another full inspection of Gleann Alainn in January 2012. The implementation of the recommendations made in this report will be thoroughly assessed at that time.

1.1 Methodology

In this inspection, inspector's judgments were based on evidence of findings verified from several sources. They were gathered through direct observation of the interactions between staff and children, interviews with three children, three parents, one Acting Unit Manager, two Acting Deputy Managers, five unit staff, four social workers, the National Manager for Special Care and High Support, the HSE Monitoring Officer, three Guardians-ad-Litem, an inspection of the accommodation, and an examination of relevant records and documentation as detailed below. Inspectors had access to the following documents:

- the unit's statement of purpose and function
- the unit's policies and procedures
- the unit's register
- the children's care files
- census information on children

- census information on staff
- details of unauthorised absences
- details of single separation
- details of physical restraint
- administrative records
- staff rosters
- staff supervision records
- fire safety documentation
- the HSE's Monitoring Officer's reports
- reports and updates relating to an unauthorised absence that occurred immediately prior to the inspection
- a document proposing an 'Arrangement to Provide Child Psychiatry Cover for Gleann Alainn'
- completed questionnaires from children, social workers, parents and external professionals.

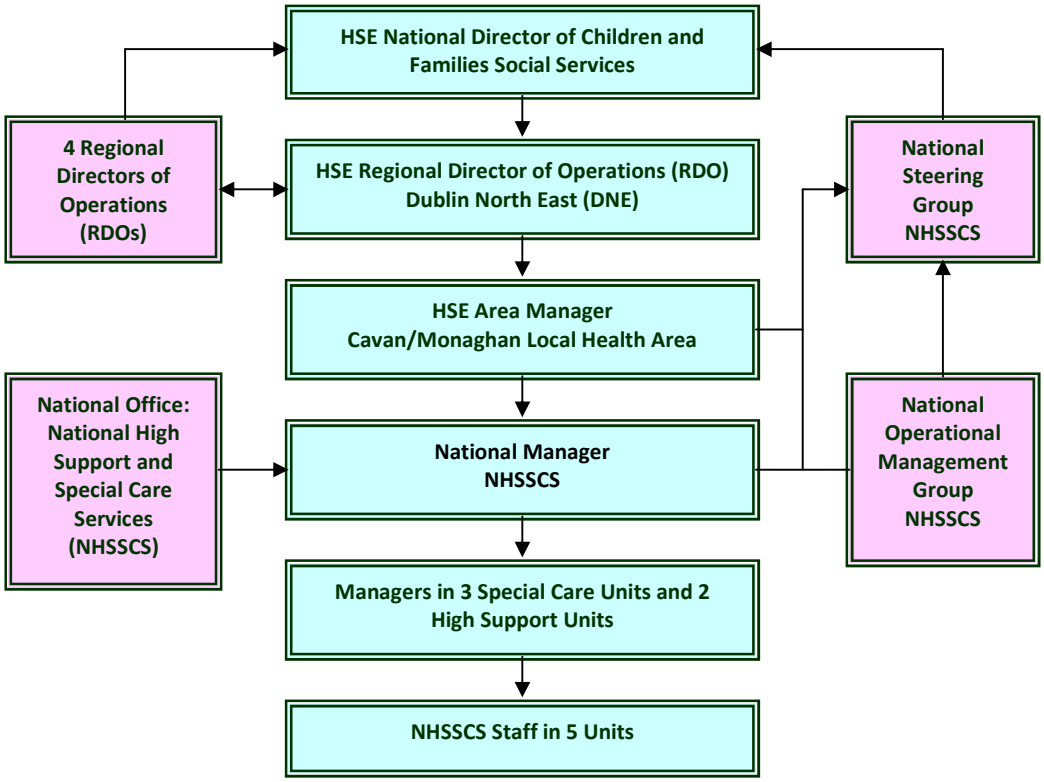
1.2 Management Structure

Some days prior to the inspection, the Acting Unit Manager had requested to step down from the post. A new Acting Unit Manager was due to take up the position a week after the inspection fieldwork (see Key Findings below).

At the time of the inspection, the SCU's management structure provided for the day-to-day operation of the unit to be managed by an Acting Unit Manager supported by two Acting Deputy Unit Managers. The Acting Unit Manager reported to the National Manager for Special Care and High Support, who had responsibility for the three SCU's in the State. The National Manager Special Care and High Support reported to an HSE Dublin North East (DNE) Integrated Services Manager. The current management structure functioned under the aegis of the DNE Regional Director of Operations. The management structure is shown on the next page.

The SCU was staffed (including the Acting Managers) by 22 full-time permanent childcare leaders and one part-time temporary childcare leader. It also had 10 agency staff and four relief staff that provided cover for staff leave or illness.

HSE SPECIAL CARE & HIGH SUPPORT SERVICES - GOVERNANCE AND MANAGEMENT STRUCTURE
OCTOBER 2011



1.3 Data on children

Inspector's examined a copy of the unit's register and it showed that 18 children had been detained there since May 2010. One child was admitted to the unit on two occasions.

Children placed in Gleann Alainn in order of length of placement - 18 October 2011[1].

Child	Age	HSE placing region	Length of placement	Number of previous placements
#1	16 years	HSE West	11.5 months	2 Residential Care, 6 Foster Care
#2	17 years	HSE South	10 months	2 Residential Care
#3	16 years	HSE Dublin North East	8 months	3 Residential Care, 1 Foster Care 1 Special Care
#4	16 years	HSE Dublin Mid-Leinster	5 months	3 Residential Care, 1 Foster Care 1 Special Care
#5	16 years	HSE South	1.5 months	2 Residential Care
#6	15 years	HSE Dublin North East	1 month	3 Residential Care, 4 Foster Care 1 Special Care
#7	16 years	HSE South	1 month	3 Residential Care, 5 Foster Care

1.4 Acknowledgments

Inspectors wish to acknowledge cooperation of the children, parents, managers, SCU staff and all other professionals that assisted in this inspection.

[1] Details of care placements were provided by the children's assigned social workers in Social Work Questionnaires

2. Summary of Findings

The key findings of the inspection were:

- that in the year prior to the inspection the standard of management of the unit was not met
- that the poor standard of management of the unit had a negative impact on the level of care provided to the children, on staff practices, and on the SCU's capacity to provide safe, secure care.

As a consequence of these findings, inspectors have made recommendations specific to the management of the unit in the delivery of safe, secure care. It concentrates on areas of practice that required an immediate response from the HSE.

However, it is important to note that although there were times when the staff were not fully in control of the unit, there was evidence of times when there were good relationships and warmth between staff and children. Children interviewed by inspectors said that being in the unit was of benefit to them, and that they had positive relationships with individual members of the staff team.

Education was provided in the unit by the Cork Vocational and Educational Committee (VEC), and although attendance by some of the children was sporadic, each child had an individual educational programme aimed at improving attendance levels and educational achievements. One child was in the process of transferring to mainstream school and this was very positive for her.

3. Findings

Management and Monitoring
Inspectors found that the standard on management of the SCU was not met. The SCU was managed by an Acting Unit Manager who was supported by two Acting Deputy Managers. She reported to the National Manager for Special Care and High Support who had line management responsibility for all three SCUs in the country. Some days prior to the inspection, the Acting Unit Manager had requested to step down from the acting post. She remained in post at the time of the inspection, but another Acting Unit Manager was due to take up the position three days after the inspection. Inspectors were told that the HSE intended to fill the acting posts on a permanent basis early in 2012.

Inspectors were told by the National Manager for Special Care and High Support that the standard of management of the SCU had been a cause for concern to him for some time prior to the inspection and that the situation had escalated since July 2011. Several supports were put in place to address these concerns, and they included increased supervision for the SCU Acting Unit Manager and ongoing monitoring of the SCU by the National Manager for Special Care and High Support.

In addition to this, a National High Support and Special Care Services Implementation Plan was developed for 2011-2014. This included a structure that provided additional supports to all SCU managers through various management groups and the assignment of specific roles to individuals. One of these, for example, was to support SCU managers to implement the action plan and any other recommendations made to individual services.

However, inspectors found that these supports did not ensure that the standard of management of this SCU was met and that all necessary actions were taken to remedy the situation in a timely manner. Inspectors found that the impact of the lack of effective local management of the SCU on the delivery of care to the children and on staff practices was considerable.

A review of unit records and interviews with unit staff, children and external professionals showed that the lack of effective management of this unit was represented by:

- care practices that did not fully meet the Regulations and National Standards
- periodic loss of control of children's behaviour
- evidence of children presenting disturbed and extremely high-risk behaviour
- significant episodes of children going missing from the care of the SCU
- a serious breach of security in the theft of a set of keys by a child
- inadequate awareness of risk and the measures needed to keep the SCU secure at all times
- staffing arrangements that did not assure the provision of safe care
- poor levels of accountability for day-to-day practice
- a lack of implementation of all of the unit's policies, procedures and protocols
- poor communication and consistency across the staff team
- a lack of staff supervision
- poor communication between the unit and external professionals
- instances of inaccurate recording of information on children and the day-to-day practices and duties of the staff team
- serious deficiencies in the prompt notification of significant events
- non-implementation of the HSE's Monitoring Officer's recommendations
- inadequate managerial systems for quality assurance of practice
- dissatisfaction from external professionals with the level of therapeutic care provided to some of the children
- the lack of a timely and effective response by external managers to ensure the standard on management was being met.

Subsequent to the inspection, on 18 November 2011, inspectors were provided with a draft HSE action plan dated 10 November 2011. This outlined the immediate objectives for 2011 in relation to the SCU and included responses to the initial findings of this inspection communicated to the external managers of the service in October 2011. There was also a senior manager in place, whose task was to support the new Acting Unit Manager and oversee the implementation of the action plan.

The HSE Monitoring Officer for the unit had identified and made recommendations regarding several of the issues above. His recommendations were made in relation to: the poor standard of unit record keeping and filing systems, staff supervision and training, the unit's need to review and develop its policies and procedures, the need to make the unit a safe and welcoming place for children, and the need for consultation with children. It was confirmed by the Monitoring Officer that these recommendations were not implemented by the SCU managers and it was his intention to address this with senior HSE managers. He was also in the process of developing a new monitoring strategy for the SCU and a new schedule of future visits.

Although a change in the management of the unit was imminent, inspectors had concerns about the governance of the SCU, primarily the existing reporting arrangements between SCU managers and the National Manager for Special Care and High Support.

Inspectors were of the view that reporting structures and quality assurance were areas that required immediate attention, along with a strategic and effective approach to ensure progress and the delivery of safe effective care by the unit. A priority agenda for all the external managers of the service is to take all actions necessary to ensure that the unit is compliant with Regulations and Standards.

Staffing
The SCU was staffed by 22 full-time permanent childcare leaders and one part-time temporary childcare leader (including the Acting SCU Managers). It also had 14 agency staff that provided cover for staff leave or illness. Unit records showed that:

- while the Acting Unit Manager was suitably qualified, many staff were not
- Garda checks were not in evidence for some agency staff
- not all agency staff had three references
- some references for agency staff had been provided from managers within the SCU
- some agency staff had not received induction training in accordance with SCU policy
- some agency staff had not received training in *Children First: National Guidance for the Protection and Welfare of Children*.

Inspectors found that the frequent and inconsistent use of agency staff did not provide a stable environment for the children, and this was confirmed by children interviewed during the inspection. It was also found that this did not provide a consistent and satisfactory quality of practice from shift to shift. This was confirmed through interviews with unit staff and external professionals working with the children.

The findings of the inspectors in relation to the impact on staff practices of the inadequate management of the SCU are outlined under *Management and Monitoring* above.

Care of young people
The children who were interviewed by inspectors, and who completed questionnaires, said that although they did not want to be placed in the SCU, they understood why they were there and thought it would be of value to them and to their futures. They also told inspectors, that they had built good relationships with some of the staff team.

They said that they did not always feel consulted by the staff or listened to when they raised issues they felt were important. They confirmed that they had access to a female doctor when they needed it, liked the food they were given, could get snacks when they wanted them, had enough pocket money, and adequate clothes and toiletries.

However, they also said that they did not always feel safe in the SCU, and mentioned particularly bullying and assaults by other residents. This was unacceptable. All children in care, irrespective of the setting, have a right to feel safe and have their welfare and development promoted. Where inspectors found specific instances of bullying and assaults they reported them to the assigned social workers. Bullying should be reported as a child protection concern, and staff should be aware of its impact and equipped to deal with it. It has a potent impact in enclosed environments, where children are in close proximity to each other 24 hours a day.

Through unit records, interviews with staff, and interviews with and questionnaires completed by external professionals, inspectors found that the delivery of care by the staff team:

- was inconsistent
- often did not keep the children safe
- was often not in keeping with good practice.

Inspectors found that:

- the staff team were not confident, correct or proficient in their classification of child protection concerns
- reporting of significant events was not always prompt, or in accordance with National Standards, HSE policy and special notification arrangements for individual children
- extreme challenging behaviour by some children was not dealt with appropriately by the staff
- there was unnecessary and excessive reliance on the Gardaí to manage children's behaviour
- children were not routinely consulted and had little influence on daily routines and practices
- unit records were not accessible to children because staff lacked a clear understanding about the child's right to access information
- the space available within the unit did not provide the children with sufficient assured privacy
- there was poor shift/team planning in relation to programmes of activity within the unit and trips out of the SCU, particularly during the evenings and in the summer months
- some practices were of a poor standard and institutionally driven, such as locking the children in their different bedroom sections by 7.30 p.m. This practice was unknown to all of the children's families and the professionals working with them.

Unauthorised absences

Information provided by the SCU showed that there were 25 unauthorised absences in the year prior to the inspection. The records provided were in relation to five children, and the absences ranged in duration from 30 minutes to six days. However, the information did not include an extended period of absence for three children, two of whose absences were notified to the Authority before the inspection. Inspectors could not assure themselves that they had been provided with accurate information about all absences as the records were incomplete and inconsistent.

Inspectors requested details of all incidents where children were separated from the other children (single separation) in the year prior to the inspection. This information was found to be unreliable, as inspectors were told by an external professional working with one child that single separation had been used for an extended period of time. Due to the poor quality of records in the SCU, the managers were unable to provide inspectors with reliable information.

Inspectors requested details of all complaints made to the SCU in the year prior to inspection. They were told that there were none, and an examination of care files showed that none had been recorded. However, one external professional had told the Authority prior to the inspection that they had raised numerous concerns with the SCU about consistency of care provided to a child and the poor level of reporting by Gleann Alainn staff of events and daily activities of this child and her night-time routine. These were not recorded on the child's care file and although inspectors requested a written update on the status of these concerns, it was not provided by the unit. This was unacceptable. Following the inspection, inspectors requested that this be addressed as a matter of priority by the National Manager for Special Care and High Support.

The details of all physical restraints in the centre in the year prior to the inspection were also requested from the unit by inspectors. The information provided by the SCU was found to be inaccurate. For example, there was no formal notification of an incident in which one child was physically restrained by a Garda on one occasion, even though this incident was described by a number of staff during interview, and was recorded in other unit records.

In relation to the promotion of good order in the unit, inspectors found through an examination of unit records and interviews with staff and external professionals that:

- the unit staff did not adequately record sanctions applied or consequences for children who displayed unacceptable behaviour, as required by the National Standards
- the unit staff did not refer serious instances of bullying as child protection concerns[2]
- the unit staff did not adequately record how bullying was dealt with by the staff team, although there had been evidence of bullying in the unit immediately prior to the inspection
- fundamental requests, such as going to bed at the required time was not adhered to by some of the children on many occasions and that this went unchallenged or was dealt with ineffectively by the staff members involved[3]
- some staff were afraid of one child and this was not dealt with appropriately by the unit managers
- the children interviewed told inspectors they had experienced incidents where the staff were not in control in certain situations
- unit records did not provide evidence of managers monitoring staff practices in relation to the management of behaviour.

The consequence for the children of all these findings was that they did not receive a consistently good standard of effective, safe care.

Premises, Safety and Security

Inspectors found that this unit's practices and systems did not always ensure that it was a safe and secure environment. Primarily, unit records and interviews with staff members showed that the staff did not consistently implement unit policies, developed to ensure the unit was as safe and secure as possible, and that the implementation of unit policies was not ensured by the unit's managers.

For example, the unit had a policy for making sure that children did not bring contraband items such as drugs or cigarette lighters back to the unit following unsupervised leave. Inspectors found that the implementation of this policy depended on an arbitrary decision made by individual staff members who based their decision on how well a child was progressing in their placement planning programme.

One week before the inspection fieldwork, a child took a set of unit keys from a staff member when out on a mobility trip. On return to the unit, and following the staff member's realisation that the keys were missing, a search of the SCU, and if necessary the child, should have taken place, but did not. The loss of the keys was not reported to the Acting Unit Manager, and no risk assessment was carried out to identify and minimize the risks this posed to the unit's security or the safety of the children.

[2] Section 9.4 *Children First: National Guidelines for the Protection and Welfare of Children 2011*
[3] Article 15: S.I. No. 550/200 *Child Care (Special Care) Regulations 2004*

There was no written risk assessment of potential risks such as access to staff offices, and therefore, to medication and children's confidential information. As a result, two children were able to leave the unit in the early hours of the morning and were absent and at risk for an extended period of time. Records of the events of that night were found by inspectors to be poor and a review of staff practices on that occasion depended heavily on recall of memory, and highlighted the need for robust recording and reporting systems within the unit. At the time of the inspection the missing keys had yet to be recovered. The external locks of the unit had been changed in order to reduce the risk of children leaving the unit.

Since the inspection fieldwork, both children have returned to the SCU. However, inspectors found through an examination of records and interviews with unit staff, children and external professionals that:

- this incident was not reported to the assigned social workers of all of the children living in the unit at that time
- the incident did not immediately impact on unit practices
- recording of the allocation to and returning of keys by each staff member remained unsatisfactory
- staff members continued to take full sets of keys off of the unit on occasion.

Inspectors formed the view that that all these practices continued to compromise the security of the unit on an ongoing basis. They were concerned that lessons had not been learned from the similar episode in 2008, following which the use of spaces within the overall structure of the unit and staff practices regarding security, particularly in respect of keys[4], were meant to have undergone radical reform.

The SCU keys remained missing at the time of writing this report. At the time of the inspection, external locks had been changed but inspectors were of the view that there remained security and safety issues. These issues were that internal door locks were not changed and possession of the missing keys by an unauthorised person would allow unrestrained access to most areas of the unit other than the three manager's offices. Inspectors were assured by the National Manager for Special Care and High Support that the internal locks were changed following the inspection.

The National Manager for Special Care and High Support also assured inspectors that this incident was subject to a full investigation that would be carried out by investigators external to the HSE. Separate to this inspection, a parallel process was put in place by the Authority to ensure that the HSE provided updates on the development of the investigation's terms of reference, its progress, and the ongoing status of the children missing from the Unit. This will continue until this matter is brought to a conclusion and the Authority is assured that standards will be met in the future.

Risk assessments were found to be routinely carried out by the SCU in relation to individual children's mobilities (outings from the unit) but not for all other areas where risk was present. One example of this was when the set of unit keys went missing. The National Manager for High Support and Special Care assured inspectors that this was rectified following the inspection.

[4] Standard 6.34 of the *National Standards for Special Care 2001* requires of SCUs that: *Systematic and scheduled security checks are carried out as part of the routine premises checks;* and Standard 6.35 requires the administration of keys and the locking of doors to be well managed.

A '*Design Process-Safety and Health Plan'* drawn up by an engineer prior to the commencement of maintenance works in the SCU was provided to inspectors subsequent to the inspection fieldwork. This included broad guidelines on the management of risk for those carrying out the maintenance works in the unit and unit staff. Inspectors witnessed serious situations when these guidelines were not adhered to.

A Health and Safety Audit, dated April 2011, was also provided to inspectors subsequent to the inspection fieldwork. This stated that risk assessments for the SCU needed to be reviewed, and that the most recent risk assessment was in March 2009. Furthermore, inspectors found that the SCU local managers and staff had not carried out local risk assessments on the maintenance works being carried out in the unit and had not developed a unit and shift plan that would ensure these risks were minimised or eradicated on a day-to-day and shift-to-shift basis. This was a serious breach of the security and safety of the unit.

A matter of grave concern to inspectors was their finding through examination of unit records and interviews with external professionals that several serious incidents, including incidents of self-harm, had taken place in the SCU. These were inadequately recorded, and in some cases not notified appropriately in accordance with the National Standards. Inspectors could not determine the exact number of these incidents or determine whether or not they had been appropriately notified to social workers. Inspectors also found that following serious incidents, the SCU did not routinely carry out risk assessments. This was of serious concern to the inspectors. It was also found that the specific type of knife (a Hoffman knife used to remove ligatures) was not readily accessible to the staff team.

The physical condition of the unit presented areas of concern to inspectors and although works were in progress at the time of the inspection to strengthen door frames and ensure door locks were in good working order, attention to other issues was required as a matter of urgency. For example, there was an unlocked shed at the rear of the unit containing numerous flammable materials and other objects that could be used as weapons that was accessible to any child who was outside the secure fence. Inspectors were allocated a set of keys for the duration of the inspection and experienced considerable difficulty in locking and opening the unit's internal doors. Staff were assigned the task of counting sharp instruments, such as carving knives in the kitchen. However, there was no list of sharp instruments and no record of routine checks, and inspectors were not given a satisfactory answer as to why this was the case. This was unacceptable.

The unit was not decorated to a good standard and required considerable attention. A television that had been broken during the summer was not replaced, and the door to a sitting room that was removed after damage had not been replaced. The children were confined to a small space from 7.30pm onwards (see also care of young people) and although they had televisions in their bedrooms they did not have any television stations. Instead, they had access to DVD players. The children told inspectors that the evenings were particularly boring for them. One child's bedroom was located on the school corridor and this was unacceptable.

Overall, this unit was not decorated to a good standard, was not maintained to a good standard, particularly one that ensured it operated at its optimum level of security and safety. Staff practices were poor under this standard, and inspectors were of the view that more attention should be given to the mix of children living in the unit. Risk assessments were of a poor standard and generally, the unit requires a full Health and Safety Audit that identifies all of the hazards and risks present, including elements that provide a potential for self-harm, and a detailed plan to address them.

4. Recommendations

To meet the Standards, the HSE should ensure that:

1. the unit is managed in accordance with Regulations and National Standards and that it meets its purpose and function by providing secure, safe care
2. the management of the unit is reviewed continuously in order to satisfy itself that it is:
   - fit for purpose
   - has quality leadership
   - has a managerial structure in which staff are accountable and supported
   - reviewing, developing and implementing appropriate unit policies, procedures and protocols
   - reviewing, developing and implementing robust, safe and accountable recording and reporting systems, particularly those related to child protection
   - constantly reviewing by managers the number of children the unit has the capacity to care for without compromising its viability
   - providing safe, secure care to all children placed in the unit
3. the unit has robust, dependable and effective external management, monitoring and quality assurance systems
4. the unit is adequately staffed to provide safe, effective care
5. all staff are appropriately vetted, trained and supervised
6. the unit is decorated and maintained to a good standard
7. the ongoing assessment, identification and addressing of areas of risk and hazards are routine practices within the unit.
8. a review of care files for each child living in the unit at the time of the inspection is carried out in partnership with the children's assigned social worker to ensure that all child protection concerns and significant events have been identified, recorded and dealt with appropriately. This review should also ensure that all records pertaining to these children are accurate and up-to-date.

5. Conclusions

This inspection found that the Standards in relation to management, staffing and security were not met and that the delivery of a good standard of care to the children required improvement and close monitoring by managers.

This unit requires immediate attention from the HSE, particularly in relation to:

- the provision of safe and effective care to the children living in the unit
- the quality of management and reporting structures
- the implementation of HSE policies, procedures and protocols
- staff practices and the monitoring and quality assurance of these practices
- the assessment, identification and management of risk
- the management of behaviour
- staff practices and recording and reporting related to child protection and significant incidents
- the unit's recording and notification systems.

6. Next Steps

The Authority will report its findings in relation to Gleann Alainn SCU to the Minister for Children and Youth Affairs.

The National Manager for Special Care and High Support should continue to provide the Authority with updates in relation the ongoing investigation into one incident.

Having considered the seriously concerning nature of the findings of this inspection, and the unit's and the HSE's failure to meet the required standards, it is the intention of the Authority to carry out another full inspection of Gleann Alainn in January 2012. The implementation of the recommendations made in this report will be assessed at this time.

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