Hinshaw Street Residential Children's Unit
Care Home Service

30 Hinshaw Street
Glasgow
G20 7DW

Telephone: 0141 276 3978 / 9

Type of inspection: Unannounced
Inspection completed on: 3 November 2017

Service provided by:
Glasgow City Council

Service provider number:
SP2003003390

Care service number:
CS2003047092

About the service

The Care Inspectorate regulates care services in Scotland. Information about all care services can be found on our website at www.careinspectorate.com

The service was first registered with the Care Inspectorate on 22 June 2016.

Hinshaw Street Residential Children's Unit is a care home for children and young people and is managed by Glasgow City Council Social Work Services. The property was purpose built during 2016 and is located in the Firhill area of the city. The service is close to all main transport links. The service accommodates up to eight children and young people.

The house is a two storey building, comprising two lounges on the lower floor, as well as a large kitchen/dining room, laundry, bedroom, bathroom and office space. On the upper floor, there are individual bedrooms with ensuite facilities. The house was well resourced, with TVs, games consoles and other age appropriate games. The garden is laid mainly to the rear and affords young people space to relax.

The service aims include:

"We hope to provide a nurturing and supportive environment to allow young people to live and grow and achieve their full potential".

What people told us

We met with four young people during this inspection who were happy to speak about their experiences of living at Hinshaw Street.

A young person who had recently come to live at the service, told us that in general, "things were OK", and "apart from some young people, it was an OK place to live". They told us that they had everything they needed in their bedroom and that they could enjoy privacy in their personal space.

One young person who had lived at the service for some time, spoke about being able to speak to most staff if they needed support or guidance with a concern. The young person told us that they had celebrated their birthday by going out to the theatre followed by a meal and that they had enjoyed this experience. They spoke at length about the impact of other young people's behaviours and commented that they found this difficult to deal with at times. They said that they felt staff could do more to address these difficulties. This view was mirrored by another young person, who also commented about behaviours which impacted upon their quality of life within the service.

Our discussion with a third young person highlighted that they were experiencing difficulties with some elements of living at the service. They said that they get bored when in the house and that sometimes other young people displayed threatening behaviour toward them. They identified staff that they didn't get on well with and said that if they had a problem, they were unlikely to speak with staff about their concern. They commented that they would be more likely to talk to another young person. We asked if they spoke with their Children's Rights worker and they confirmed that they had discussed concerns with them. We spoke with two advocacy workers, to confirm their awareness of issues raised by young people during this inspection.

We also spoke with two parents who commented that they were happy with the support for their children and felt that communication between them and the service was good. Both parents said that they felt involved in plans to support their children and were aware of the challenges facing them.

Self assessment

The provider was not required to submit a self assessment document for this inspecting year.

From this inspection we graded this service as:

Quality of care and support	2 - Weak
Quality of environment	5 - Very Good
Quality of staffing	2 - Weak
Quality of management and leadership	3 - Adequate

Quality of care and support

Findings from the inspection

Within the context of the grade awarded for this quality theme, we acknowledged that the service had supported some young people with very complex and challenging needs. This was in line with the provider's responsibility to support looked after children and young people who present as the most vulnerable. However, upon review of this quality theme, we awarded a grade of weak, further to our observations of practice, discussions with young people, families, staff and external stakeholders. We also sampled records relating to young people, to support our findings from this inspection.

We spoke with four young people who were happy to discuss their experiences of living at the service. For those who were longer term residents, we heard that they felt they had good relationships with most staff and that they recognised Hinshaw Street as their home. The quality of outcomes was generally better for two young people who had well developed relationships with staff. For example, the service worked hard to create the right conditions for one young person to successfully transition from school to college. In this instance, the stability provided through positive relationships with staff and their considerable knowledge of the young person, supported the young person's continued opportunities within education. Another young person showed their ability to sustain commitment to working with services whose aim was to promote the health, social and educational needs of young women. The young person who had previously been closely supported through the provider's vulnerable young people procedures, due to significant concerns about their personal safety, was engaging more routinely with supports and was making more positive choices about how they wished to spend their time. We also found that under very difficult circumstances, the service had supported some young people to successfully move on from the service, on a planned basis, to placements considered more suited to their needs.

However for others, it was evident that relationships were more superficial and in some instances poor, as confirmed by some young people and staff during our visits. The inability of the service to develop and maintain positive relationships with those young people, meant that they were prevented from developing a positive sense of self and wellbeing. An example of the impact of poor relationships, was that some young people continued to be highly disruptive and largely disengaged from supports, presenting significant challenges to the service, and at times to other young people. During our discussions with placing social workers, it was acknowledged that this was the case and that work was on-going to consider alternative placements.

During our discussions with young people, they confirmed that they were unhappy about the level of disruption at times, particularly bedtime and throughout the night. As these concerns were known to the service, we explored what strategies were in place to minimise the impact on young people and ensure that their views were central to decisions to reduce any negative experience. We also spoke with advocacy services who confirmed that young people had raised this with them. We were advised that they viewed it with concern and had alerted senior managers to the views of young people. In our view, it was clear that staff offered reassurance to young people during such difficulties, but it was also evident that interventions were not well thought through and were being applied inconsistently, therefore proving to be ineffective. For example, we found that young people causing disruption remained in their bed, sometimes until late in the day and this meant that they were more likely to remain awake until late in the night, with the cycle of disruption continuing. Similarly, for those young people who were assessed as being at risk in the community, often frequenting unsafe areas across the city, this meant that outcomes remained poor, due to little change in these circumstances.

We sampled records for six young people living at the service and from many of those records it was difficult to see how the service worked to ensure that young people were supported to achieve positive outcomes and to be kept safe within the community. Most young people did not have an up to date personal plan to evidence how staff helped them to meet their needs or support their aspirations for their future. We have made a requirement regarding the need for personal plans which help to show how the needs of young people are being assessed and supported by the service. (see requirement 1 under this quality theme).

Although young people had weekly planners to show how they might spend their time, these were simply timetables to show where young people were expected to be throughout the week. In these, we found significant 'free time' was allocated to each young person. When we explored this with young people, some stated that as they did not attend school or participate in most planned activities, they spent considerable time doing little within the house. We were concerned that for younger children, this was harmful to their growth and development. We did find that a few young people had engaged in structured activity and had developed relationships with other agencies, however there was variable commitment shown to this by young people. It was clear that most had their own lives outwith the service and we found little evidence to demonstrate how staff were proactive in encouraging increased engagement and as such, it was difficult to measure progress toward better outcomes.

Risk assessment and risk management practices formed part of this inspection. We recognised that almost all young people living at Hinshaw Street, presented with high risk behaviours and/or non compliance with requests to lead healthier, safer lifestyles. As a result, we felt that interventions to reduce risk, were met with limited success. We did however note that there were a range of well established processes in place, to allow professionals to meet regularly to discuss young people's welfare. From documentation, we could see that representatives involved, met to agree and review plans aimed at addressing concerns and as previously stated, we found that the provider's approach to supporting the most vulnerable young people had impacted positively for one young person considered to be less at risk.

Some interventions however, did not make a sufficient impact upon some young people's lives and we found that they regularly absconded or failed to return to the service and did not keep in touch to allow staff to assess their safety and whereabouts. In some instances those young people had encouraged others, sometimes much younger than they, to abscond with them and put themselves at risk. Although risk assessments for most young people identified risk behaviours, individualised safety plans were either not in place to manage young people's safety and wellbeing, or did not adequately address known risks. Given our concerns regarding the safety and wellbeing of several young people living at Hinshaw Street, we have made a requirement that risk management plans should be reviewed and should take account of all known risks and how these will be managed by the provider. (see requirement 2 under this quality theme).

When considering how young people's health needs were being met, the service once again found this difficult to evidence. We identified very specific health needs for some young people, through our discussions with staff, however when we asked what supports were in place to meet those needs, we assessed that only some staff had awareness of these and this meant that there was inconsistent support to enable young people's health and wellbeing. An example of our concern related to an increase in drug and alcohol consumption for some young people, who at times, failed to take prescribed medication, due to their whereabouts often being unknown throughout the day and night. On one occasion, this misuse of alcohol resulted in a hospital admission for one young person, while on other occasions returning to the house intoxicated, led to incidences of aggressive behaviour and damage to property. We did not find any evidence of the impact, either through discussions with staff or in young people's records, of how the service was improving the quality of care and support for those misusing alcohol or drugs.

Requirements

Number of requirements: 2

1. The provider must ensure that each young person has a personal plan, detailing how staff working in the service, will support young people to met their needs and expected outcomes. Although there is no prescribed format or content for a personal plan, there is an expectation that it will be produced further to robust assessment and will meet individual needs comprehensively.

This is to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services), Regulations 2011/210, Regulation 5 (1) - Subject to paragraph (3) a provider must, after consultation with each service user, and where it appears to the provider to be appropriate, any representative of the service user, within 28 days of the date on which the service user first received a service prepare a written plan ("the personal plan") which sets out how the service user's health, welfare and safety needs are to be met.
2 (b) (iii) - Subject to paragraph (3) a provider of a care service must - review the personal plan at least once in every six month period while the service user is in receipt of a service.

Timescale: 1 month from publication of this report.

2. The provider must ensure that where there is identified significant risk to young people, risk management plans must be in place to address concerns regarding the safety and wellbeing of young people.

This is to comply with:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services), Regulations 2011/210, Regulation 4 (1) (a) - A provider must make proper provision for the health, welfare and safety of service users.

Timescale: Immediately.

Recommendations

Number of recommendations: 0

Grade: 2 - weak

Quality of environment

Findings from the inspection

Upon review of this quality theme, we awarded a grade of very good, further to our observations of the physical environment and assessment of the quality of life for young people.

Hinshaw Street had been operational for just over one year at the time of this inspection. We found during the inspection, that the house was in very good condition and this meant that young people could experience a positive quality of environment, within warm and comfortable surroundings. The spacious accommodation continued to offer young people the opportunity to spend time with others in one of the lounges or to chat around the dining table. The service remained well resourced, with a range of indoor games available to engage young people. Most young people who spoke with us during the inspection, said they liked the house and valued the privacy within their bedrooms. Some commented that their bedroom was a safe and comfortable place to relax.

As part of our review of the physical environment we were shown some of the young people's bedrooms and it was clear that these offered the privacy that young people should expect and that ensuite facilities meant that their dignity was promoted, when looking after their personal care. Bedrooms were spacious and well equipped, with evidence of young people's personal items, which for some created a sense of belonging. With the exception of some bedrooms, all other areas throughout the house, were immaculately clean and tidy. During our discussions with domestic staff members, we were told of their commitment to maintaining very good standards of hygiene and that they enjoyed making sure that the young people were looked after as best they could.

During periods of difficulty, some of the young people had impacted significantly upon the physical environment. However, the service had been proactive in seeking to repair the house and replace items broken and we found that they had been creative in considering ways to allow these works to take place, without impacting upon young people's everyday experiences. By timing the opportunity for young people to go on holiday, we found that remedial works were undertaken during this period away from the service, ensuring that young people could return to the high quality environment they enjoyed.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Grade: 5 - very good

Quality of staffing

Findings from the inspection

Upon review of this quality theme, we awarded a grade of weak, further to our discussions with young people, staff and review of current practices.

We met with six members of the care staff team during inspection who told us about their work in supporting young people. We heard that some young people sought particular staff out to discuss their care and that these relationships offered reassurance and guidance, when required. It was evident that there had been some changes within the staff group and we found that established colleagues spoke positively about these changes. We believed, further to meeting with some of the new members to the team, that they were keen to promote positive experiences for young people in their care and were seeking to develop positive relationships to help young people engage successfully with supports available.

It was clear that staff recognised the challenges in supporting young people who chose to withdraw from supports, in favour of less positive lifestyles. Some staff expressed concern about the team's ability to 'connect' with young people in meaningful ways and through minutes of staff meetings, we saw that some staff did not feel that the service was meeting many of the young people's needs. Their comments included that they did not feel they were "getting it right for any of the young people" and that there "were no positive outcomes". This was confirmed to us through discussions with some staff, during our visits, with many commenting about the unsuitability of some young people's placements and about their ability to keep them safe, or to engage them in a purposeful way. Most staff members that we spoke with expressed frustrations about their role and we sensed that there was a degree of hopelessness in the views of some staff, to effect any positive change. Whilst we agreed that some young people displayed difficult behaviours and were hard to reach at times, we did feel that there were some positive outcomes for a few young people and we discuss this more under quality theme 1 of this report.

Upon consideration of the quality of staffing, we concluded that there were significant barriers within the staff team, to meetings the needs of young people. In some instances, preoccupation with negative factors at play, prevented some staff from being able to identify or apply thoughtful interventions to better meet young people's needs. Low morale also impacted their ability to recognise how to adopt solution focused approaches to improving the experiences and outcomes for young people living at the service. With this in mind, we have identified a number of areas for improvement. These are:

- the provider should consult with the staff team to determine their views about the quality of provision for young people. This should include exploration of any negative views about placements and consider the culture and morale within the staff team. We believe that given the extent to which some staff focused on the unsuitability of placements for some young people, during the inspection, this most likely influenced their practice.

- a recent audit document produced by the provider, identified the key functions of effective supervision as, management, development, support and mediation and highlighted that formal supervision was valued by staff working across their services. However, further to sampling records for six members of staff, we found that supervision had not occurred in line with the provider's policy within Hinshaw Street. We had previously made a recommendation regarding this practice during the last inspection and have repeated this recommendation to stress the importance of this support for staff and to ensure that some of our observations of low morale within the team, can be addressed by managers. (see recommendation 1 under this quality theme).

- the service should aim to promote transparency and openness about the effectiveness of team work. A focus on improving morale and consistency of approach, should identify ways in which staff can develop better relationships with young people in their care.

- it was clear that inconsistent practices hindered outcomes for young people. The service should consider the skill mix of staff and ensure that the rota provides for the correct balance of skill, experience, enthusiasm and opportunities for development. By ensuring that there is a clear focus on common objectives, that roles are clearly defined, interpersonal relationships promote collaboration and processes create clear expectation of practice, young people living at the service will benefit from adults who work together to help them meet their needs.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 1

1. The service should ensure that all relevant staff receive supervision in line with the provider's policy. This should take account of how staff are being managed, developed and supported within their roles. By providing guidance and direction to staff, they will better understand expectations of their practice, in supporting young people to achieve better outcomes.

National Care Standards, Care Homes for Children and Young People, Standard 7 - Management and staffing.

Grade: 2 - weak

Quality of management and leadership

Findings from the inspection

Upon review of this quality theme, we awarded a grade of adequate, further to consideration of the wider improvements that are required and that are highlighted within the report.

Changes within the staff group since the last inspection, had created a new dynamic within the team. This also included the management team, with the addition of two new senior staff. We met with those staff and found that they were in the early stages of developing insight into practice at Hinshaw Street. We acknowledged that both wished to improve existing ways of working and were committed to creating the right circumstances for young people to thrive. However, we found a disjointed leadership approach within the service, with some senior staff being unclear about their role as well as those who felt less supported to understand all aspects of their remit. The manager was a consistent member of this team and therefore had extensive knowledge of the service, however we found that staff at all levels, were not receiving sufficient guidance and direction, to assist their practice. We found that many staff failed to convey a positive message about working in the service.

A further indication of the challenges facing the service included shortfalls within the staff rota leading to the manager being required to work directly with young people. This had impacted upon their ability to focus on improvement and resulted in less time to carry out daily management functions, including quality monitoring, overseeing staff supervision and progressing aspects of the development plan. A condition of registration with the Care Inspectorate, is that the manager's time is supernumerary and they should not therefore be included in staffing rotas. We believed that this had contributed to aspects of the service not working as well as they should. It was clear that the development plan had not yielded the progress or outcomes expected and other management tasks had not been completed. We have made a recommendation that robust quality monitoring practices should be implemented to address the areas for improvement outlined within this report and more broadly, within the service. (see recommendation 1 under this quality theme).

During discussions with the manager, it was identified that formal supervision meetings with their line manager, had been sporadic throughout the year, with only a few meetings taking place. We considered that elements of the National Guidance for the External Management of Residential Child Care Establishments in Scotland (2013), relating to a) - formal supervision of the manager and provision of notes thereafter, had not occurred in line with the provider's policy. We have made a recommendation under quality of staffing of this report, to reflect the necessary improvement.

During the inspection process, we were informed of the range of proactive supports implemented by external management, to help support both young people and the day-to-day work of the service. Meetings with colleagues in social work helped to raise awareness of concerns relating to specific young people and to consider alternative strategies to improve outcomes. We found that securing the additional involvement of other agencies, was intended to mitigate some of the concerns regarding risk behaviours, impacting upon young people and others in the community. Although we found that supportive decisions had been taken to manage the challenges facing young people and to support daily operational practices within the service, we believed that routine quality monitoring practices had not been implemented to ensure that all aspects of the service were working well. In order to promote positive outcomes for young people, the management of the service must demonstrate that it has implemented and evaluated quality inputs. This should include, consistent involvement of young people in identifying key aspects of improvements, encouraging positive communication and relationship based practice between young people and those providing daily supports and ensuring the safety and wellbeing of young people is being effectively managed.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 1

1. The service should implement robust quality monitoring practices to ensure that all aspects of the service operate to an acceptable standard. By ensuring that effective systems, processes and practices are in place, young people can expect that the service will operate to an improved standard, focusing on how it can meet their needs and promote positive outcomes.

National Care Standards, Care Homes for Children and Young people, Standard 7 - Management and staffing.

Grade: 3 - adequate

What the service has done to meet any requirements we made at or since the last inspection

Previous requirements

There are no outstanding requirements.

What the service has done to meet any recommendations we made at or since the last inspection

Previous recommendations

Recommendation 1

The provider should ensure that safety management plans for young people who present with high risk behaviours are robust and address all known concerns relating to young people's safety in the community. Plans should clearly state that young people are given advice about how to protect themselves against others who may cause them harm.

National Care Standards, Care Homes for Children and Young People, Standard 6 - Feeling safe and secure.

This recommendation was made on 8 May 2017.

Action taken on previous recommendation

We found that risk management plans were not in place for those young people at risk within the community. We have made a requirement to ensure that the provider addresses this area for improvement.

Recommendation 2

The service should ensure that all staff receive supervision in line with the provider's policy.

National Care Standards for Children and Young People, Standard 7 - Management and staffing.

This recommendation was made on 8 May 2017.

Action taken on previous recommendation

We found that there continued to be periods where staff had not received supervision from their manager. We have therefore repeated this recommendation.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Enforcement

No enforcement action has been taken against this care service since the last inspection.

Inspection and grading history

Date	Type	Gradings	
16 Mar 2017	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 5 - Very good 4 - Good 3 - Adequate
15 Jan 2016	Unannounced	Care and support Environment Staffing Management and leadership	4 - Good 4 - Good 4 - Good 4 - Good
27 Nov 2014	Unannounced	Care and support Environment Staffing Management and leadership	5 - Very good 5 - Very good 4 - Good 4 - Good
14 Feb 2014	Unannounced	Care and support Environment Staffing Management and leadership	4 - Good 4 - Good 4 - Good 4 - Good
11 Feb 2013	Unannounced	Care and support Environment Staffing Management and leadership	Not assessed 4 - Good Not assessed 4 - Good
24 Sep 2012	Unannounced	Care and support Environment Staffing Management and leadership	4 - Good Not assessed 4 - Good Not assessed
5 Aug 2011	Unannounced	Care and support Environment Staffing	3 - Adequate Not assessed 3 - Adequate

Date	Type	Gradings	
		Management and leadership	3 - Adequate
10 Nov 2010	Unannounced	Care and support Environment Staffing Management and leadership	5 - Very good Not assessed Not assessed Not assessed
14 Jun 2010	Announced	Care and support Environment Staffing Management and leadership	5 - Very good 5 - Very good Not assessed Not assessed
2 Mar 2010	Unannounced	Care and support Environment Staffing Management and leadership	5 - Very good Not assessed 4 - Good Not assessed
22 Sep 2009	Announced	Care and support Environment Staffing Management and leadership	5 - Very good 5 - Very good 4 - Good 5 - Very good
27 Mar 2009	Unannounced	Care and support Environment Staffing Management and leadership	6 - Excellent 5 - Very good Not assessed Not assessed
26 Jan 2009	Announced	Care and support Environment Staffing Management and leadership	6 - Excellent 5 - Very good 5 - Very good 5 - Very good

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