Short Breaks for Children
Care Home Service

Shetland

Type of inspection:
Unannounced

Completed on:
7 February 2026

Service provided by:
Shetland Islands Council

Service provider number:
SP2003002063

Service no:
CS2003009602

About the service

Short Breaks for Children provides a short breaks service for young people in two separate properties close to the town centre of Lerwick, Shetland.

The service at Laburnum House provides overnight short breaks for a maximum of six children and young people with learning difficulties and multiple complex needs, with a further two young people being cared for at a smaller property at Haldane Burgess Crescent.

About the inspection

This was an unannounced inspection which took place on Sunday 18 and Monday 19 January 2026. The inspection was carried out by one inspector from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- met with people using the service
- spoke with staff and managers
- observed practice and daily life
- reviewed documents
- received feedback via questionnaires from parents, staff and external professionals.

Key messages

- All of the staff were committed to, and enthusiastic about, the young people they cared for.
- Staff understood the needs of the young people and were keen to ensure they had really positive experiences.
- The organisation needed to radically review how short breaks and outreach support were provided in order to minimise cancellations and provide stability and consistency.
- Team building and effective use of team meetings needed to be prioritised to support a cohesive team and address issues of mistrust and poor staff morale.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support children and young people's rights and wellbeing?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support children and young people's rights and wellbeing?

3 - Adequate

We evaluated key question 7.1 as good, where several strengths impacted positively on outcomes for children/young people and clearly outweighed areas for improvement. We evaluated key question 7.2 as adequate meaning there are some strengths, but these just outweigh weaknesses.

High levels of attentive staff support ensured young people were safe. Staff had a good understanding of their individual and specific needs both within the house and in the community.

Restrictive practices were considered. All of the team described closed or locked doors only when necessary to ensure safety, however, in specific circumstances greater discussion amongst the 'team around the child' would ensure that certain strategies of support were well considered, recorded and reviewed.

Staff were aware of safeguarding procedures, had received training and knew what to do if they had concerns. On call provision ensured that there was always a senior member of staff available for guidance and support.

The team knew young people well and used their knowledge and relationships to provide stable care and support within a safe environment. The staff were committed and enthusiastic about the young people they cared for.

The team understood the need for planning and structure for young people, whilst giving the young people choice about how they spend their time. Staff were hugely respectful to, and about, young people and wanted to provide the best possible experience. Young people clearly benefitted from warm and nurturing relationships with staff.

Quarterly newsletters were a cheerful and positive way of sharing information with families. They included pictures of young people engaged in fun and interesting activities. The 'Shetland for Bairns' video was an excellent presentation by the young people.

Medication was only stored during young people's short breaks and was signed in and out. Medication procedures were not sufficiently robust. Where audits had identified errors there had been no remedial action or evidence of improvement. Medication errors had not been notified to the Care Inspectorate as required. (See area for improvement 1.)

The physical environment across the two houses was very different. One provided a smaller more homely space which was well-maintained, where the other was much less so. Many previous inspection reports had assessed the building at Laburnum as restricting innovation and service development. At this inspection the limitations of the Laburnum building continued to restrict the service's ability to develop innovative models of support for children with complex needs. A strategic review of the physical environment, alongside future service design, would support longer-term sustainability. Staff continued to try to make the spaces in the house as young person friendly as possible, however, the building is old and poorly maintained. Remedial work appears to take place when the situation is dire and equipment unusable, rather than via a programme of refurbishment which would respect young people experiencing short breaks in an environment that is warm and welcoming and caters for their needs. (See area for improvement 2.)

Support plans were generally of a good quality and had useful strategies of support. We discussed the need

for some of the processes relating to review and audit to change slightly, but this did not impact on the quality of the support provided. Risk assessments needed to be reviewed and developed to ensure they were specific about risk and strategies of support and not generic statements which provided little rational for decisions, particularly in relation to lone working. (See area for improvement 3.)

There had been significant changes and periods of absence across the manager and senior team, which had contributed to a sense of uncertainty and significantly affected team cohesion and morale. There was a need to re-establish stability, strengthen leadership presence, and rebuild a positive and cohesive team culture. This would ensure staff worked together more consistently to support the children and families they support.

We continued to find (as per previous inspections) that 'Senior staff spent a large amount of their time completing administrative tasks, significantly reducing their important role in modelling good practise and supporting staff'. This had contributed to an unhelpful culture and a divided team. Addressing this will be key to strengthening leadership, enabling senior staff to spend more time alongside colleagues and young people, and to a more unified and supportive team culture.

The current approach to allocations and rotas was ineffective and needed significant change to provide stability and consistency to children and their families. Parents reported that when their children had time at Short Breaks, they had a good experience with caring staff, however, they were dissatisfied about the impact of regular cancellations. Documentation evidenced that rates of cancellation were extremely high, and continuing to increase. This was further evidence of the need to radically review how short breaks and outreach support were delivered to ensure reliability and sustainability. (See area for improvement 4.)

Staff absences, both anticipated and not, had highlighted the need for timely and responsive workforce planning. Strengthening approaches to reallocating senior support and undertaking an effective staffing needs assessment would support both the service and the wider organisation to better understand the staffing required to meet the complex needs of children accessing short breaks, and to ensuring realistic planning for the provision of a reliable and sustainable service for families. (See area for improvement 5.)

There was a keenness to ensure that the staff hours available were maximised to offer best opportunities for young people and their families. Changes in both the rota and allocation of additional tasks had sometimes been difficult for staff to understand, feeling there was little consultation to changes and expectations. A greater distinction between managerial and senior tasks would support more effective team working and enable senior staff to prioritise direct practice and support, and ensure staff receive regular, meaningful supervision. Strengthening these supportive structures, alongside purposeful team meetings, would play a key role in improving morale and fostering a collaborative team environment. (See area for improvement 4.)

Auditing tools had been developed which provided an overview of key documentation. A comprehensive action plan detailed decisions about agreed changes and decisions. The introduction of a development plan would ensure an aspirational and forward-looking approach, including how the service meets the important messages of the Promise (a document to support the transformation of how Scotland cares for its children). (See area for improvement 6.)

Areas for improvement

1. Medication procedures need to be robust. Where errors are identified remedial action should identify and impact positive change. The Care Inspectorate guidance on the reporting of incidents must be followed.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24); and

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

2. To ensure young people are cared for in a high quality environment which meets their needs the provider should:

- Carry out a strategic review, alongside future service design which would support the longer-term sustainability of short breaks provision

- Ensure that the environment at Laburnum is maintained to a high standard through significant upgrade of the building and timely repairs.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I experience a high quality environment if the organisation provides the premises' (HSCS 5).

3. Risk assessments should be reviewed and developed to ensure they are specific about risk and strategies of support. They should be individual to each young person's specific need

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My care and support meets my needs and is right for me' (HSCS 1.19).

4. The organisation need to radically review how short breaks and outreach support are provided to minimise cancellations and provide stability and consistency.

They should consider:

- How allocations and rotas impact service delivery
- Clarity of roles between managers and senior staff, ensuring senior staff spend significantly more time mentoring the team and providing staff supervision
- More effective use of team meetings or other team building opportunities to develop a more cohesive staff team with greater staff morale.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My care and support is consistent because people work well together' (HSCS 3.19); and

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

5. The service should complete a staffing needs assessment to ensure the right amount of staff are available to meet the needs of young people, and as required by the Care Inspectorate (in the document 'Guidance for providers on the assessment of staffing
levels').

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My needs are met by the right number of people' (HSCS 3.15); and

'I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes' (HSCS 3.14).

6. The service should develop an improvement plan which is aspirational for the future of Short Breaks and the children and families it supports. It should be grounded in the foundations of 'The Promise' and Scotland providing the very best care to its children and young people.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I benefit from a culture of continuous improvement, with the organisation having robust and transparent quality assurance processes' (HSCS 4.19).

What the service has done to meet any areas for improvement we made at or since the last inspection

Areas for improvement

Previous area for improvement 1

The provider should review whether the current property at Laburnum continues to meet the needs of the service users and ensure any remedial work required to ensure their comfort and safety is carried out promptly.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I experience a high quality environment if the organisation provides the premises' (HSCS 5); and

'My environment has plenty of light and fresh air and the lighting, ventilation and heating can be adjusted to meet my needs and wishes' (HSCS 5.19).

This area for improvement was made on 29 March 2024.

Action taken since then
There are continued concerns re the Laburnum property. (See 'How well do we support children and young people's rights and wellbeing?')

This area for improvement has not been met and remains in place.

Previous area for improvement 2

The organisation should review the current arrangements to support families in crisis to ensure there is minimal disruption to service provision.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'My care and support is provided in a planned and safe way, including if there is an emergency or unexpected event' (HSCS 4.14).

This area for improvement was made on 29 March 2024.

Action taken since then
There continues to be significant cancellations affecting the support children and young people receive.

This area for improvement has not been met and will remain in place.

Previous area for improvement 3

The service should consider how they gain the views of families and incorporate these into plans for the future.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that:

'I am actively encouraged to be improving the service I use, in a spirit of genuine partnership (HSCS 4.7); and

'I am supported to give regular feedback on how I experience my care and support and the organisation uses learning from this to improve' (HSCS 4.8).

This area for improvement was made on 29 March 2024.

Action taken since then
This area for improvement has been met.

Complaints

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

Detailed evaluations

How well do we support children and young people's rights and wellbeing?	3 - Adequate
7.1 Children and young people are safe, feel loved and get the most out of life	4 - Good
7.2 Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights	3 - Adequate

To find out more

This inspection report is published by the Care Inspectorate. You can download this report and others from our website.

Care services in Scotland cannot operate unless they are registered with the Care Inspectorate. We inspect, award grades and help services to improve. We also investigate complaints about care services and can take action when things aren't good enough.

Please get in touch with us if you would like more information or have any concerns about a care service.

You can also read more about our work online at www.careinspectorate.com

Contact us

Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY

enquiries@careinspectorate.com

0345 600 9527

Find us on Facebook

Twitter: @careinspect

Other languages and formats

This report is available in other languages and formats on request.

Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذه الوثيقة متوفرة بلغات ونماذج أخرى عند الطلب

本出版品有其他格式和其他語言備索。

Na życzenie niniejsza publikacja dostępna jest także w innych formatach oraz językach.