

Kibble Intensive Services School Care Accommodation Service

Kibble Education & Care Centre Goudie Street PAISLEY PA3 2LG

Telephone: 0141 889 0044

Type of inspection:

Unannounced

Completed on:

11 July 2024

Service provided by:

Kibble Education and Care Centre

Service provider number:

SP2004007042

Service no:

CS2022000010



Inspection report

About the service

Kibble Intensive Services is a school care accommodation services for children and young people between the ages of 11 years and over, who are attending or transitioning to secondary education.

The service is registered to care for up to eight young people in the two houses within the service, four living within Buchanan house, and four within Bute house. The services are situated with Kibble's main campus in Paisley. It has close access to supporting services and local amenities.

About the inspection

This was an unannounced inspection which took place on the 8 - 11 July 2024. The inspection was carried out by two inspectors 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:

- Spoke with six people using the service and four of their representatives.
- Spoke with eighteen staff and management.
- · Observed practice and daily life.
- · Reviewed documents.
- · Spoke with professionals.

Key messages

- Staff and managers within the service had good knowledge of the complex needs of young people using the service and took steps to keep young people safe.
- We suggested the service should take legal advice to ensure that the balance of risk did not infringe, or unnecessarily limit the rights and freedom of young people.
- The service had good links to advocacy and young people could easily access this.
- The service had a very stable staff team with a good awareness of trauma informed practice.
- We found that the process in place for recording, notifying and learning from incidents required improvement.
- Care planning and risk assessment processes should be improved to ensure they include all relevant and up to date information.
- The service offered bespoke opportunities for young people to learn.
- Families were also able to access support from the service to help strengthen their relationships. This helped families to feel included and build lifelong relationship.
- Mealtimes were inconsistent across the houses, we highlighted areas where we felt the service could improve.

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?	4 - Good
--	----------

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?

4 - Good

We made an evaluation of good for this key question. A number of important strengths could be identified, which taken together clearly outweighed areas for improvement and had positive outcomes for young people.

Quality Indicator 7.1 Children and young people are safe, feel loved and get the most out of life

Staff and managers within the service had good knowledge of the complex needs of young people using the service and took steps to keep young people safe. We found at times that this led to limiting young people's access to time in the community and access to mobile phones. Young people told us; 'I would really like my phone back and don't know when I will get one.' We suggested the service should take legal advice to ensure that the balance of risk did not infringe, or unnecessarily limit the rights and freedom of young people. (See Area for Improvement 1)

The service had good links to advocacy, and young people could easily access this. The provider was assessing how the changing needs of young people using the service altered the way in which young people's views could be gathered. This ensured that young people felt listened to and included.

The service had benefitted from a very stable team of staff, this helped ensure that staff had a good awareness of child protection. There were, however, some gaps in training for staff in one of the houses which the service had awareness of and plans in place to address this. The service had recently updated their policy and staff had a good understanding of this. We found that there had been a concern which had not been reported to The Care Inspectorate. We were able to review the steps taken and were satisfied with the process. The service was able to reflect on this event and recognise the importance of sharing this information with the Care Inspectorate in the future.

Young people benefitted from a staff team with good awareness of trauma informed practice. Staff told us how they benefitted from the Specialist Intervention Team which facilitated a safe space to have reflective discussions and support. This helped ensure staff had a depth of understanding that supported consistency and stability for the young people.

We found that the service had processes in place for recording incidents. We found the recording at times was not detailed and missed key information such as medical assistance provided. We felt this was not effective and needed more oversight from managers. The provider had taken steps to allocate house managers more time to undertake these tasks recently. Despite that it was too early to assess the benefit of this. (See Requirement 1)

Care plans and risk assessments needed to be more detailed, and reflect the care staff provided. We found that not all known risks or strategies to manage risk were represented within these plans. We highlighted the importance of ensuring these are updated regularly to ensure young people experience consistent care which supports them to develop new skills. (See Area for Improvement 2)

Education was well accessed and supported by the service. Young people told us; "I miss school in the holidays." We found the service offered bespoke opportunities for the young people to learn. This helped support young people to grow in confidence and achieve.

The service also supported young people's time with families very well.

Young people were supported to spend extended periods of time at home where possible. Families were also able to access support from the service to help strengthen their relationships. This helped families to feel included and build lifelong relationship.

The provider had plans in place to improve the environment within one of two houses, helping to ensure that all young people using the service had the same access to space and opportunity.

We found inconsistencies in the way young people experienced mealtimes, with these often eaten and prepared separately in one of the houses. Young people and staff told us they often didn't eat the food prepared or didn't like the quality. We suggested the provider take steps to address these areas, and find ways to improve mealtime experiences for young people.

Requirements

- 1. By 30 September 2024, you must ensure to review and address any gaps in post incident notification, debrief, and future learning. In particular you must:
- a) Ensure that any use of restraint, staff misconduct, and child and adult protection issues are fully documented, include pertinent detail and are shared timeously with relevant partner agencies including the social work department, the Care Inspectorate and any other relevant agencies.
- b) Ensure that all children and young people's personal plans and risk assessments are appropriately detailed and updated regularly in relation to the use of restraint and restrictive practices. Ensure clear guidance is given to staff about safe strategies to use, based on the individual needs of the children and young people. (This must include assessment of the legal advice sought in Area for Improvement 1)
- c) Ensure that individual de-briefs are carried out with staff following all incidents where restraint has been used and that analysis of the strategies used by staff identifies staff learning to improve future practice, and supports a reductionist approach to restrictive practices.
- d) Ensure that restraint and restrictive practices are effectively overseen by quality assurance systems and managers to ensure issues are identified promptly, allowing the provider to take steps to mitigate against this.

This is in order to comply with Regulation 4(1)(a), Regulation 4(1)(c) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

Areas for improvement

1. To support the young people's wellbeing and outcomes the provider should seek legal advice to ensure that young people are not being unnecessarily deprived of their liberty.

The legal advice should be shared with the Care Inspectorate and care practices should reflect both this advice and article 5 and 37 of the European Convention on Human Rights.

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

Inspection report

'If my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively.' (HSCS 1.3)

And

'My human rights are central to the organisations that support and care for me' (HSCS 4.1).

2.

To support the young people's wellbeing, outcome, and choice the provider should review their care planning and risk assessment processes, ensuring these include the views of young people, are kept up to date and include all relevant details.

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

'My personal plan (sometimes referred to as care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.' (HSCS 1.15)

And

'I am protected from harm, neglect, abuse, bullying and exploitation by people who have a clear understanding of their responsibilities' (HSCS 3.20).

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?	4 - Good
7.1 Children and young people are safe, feel loved and get the most out of life	4 - Good

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।

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

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.