St. Mary's Kenmure
Secure Accommodation Service

St. Mary's Road
Bishopbriggs
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Type of inspection:
Unannounced

Completed on:
3 October 2024

Service provided by:
St. Marys Kenmure

Service provider number:
SP2011011646

Service no:
CS2011299188

About the service

St. Mary's Kenmure is a secure accommodation service, located in Bishopbriggs in the northeast of Glasgow, that provides 24 secure beds for young people aged from 11 to 18 years. At the time of the inspection, the service was accommodating 18 young people.

St. Mary's Kenmure is governed by an independent board of managers and is a registered charity (SC 029984). It is an approved exam centre with the Scottish Qualifications Authority (SQA), registered with the Registrar for Independent Schools, and is inspected by Her Majesty's Inspectorate of Education (HMIE).

The service has a campus-style facility, which is formed by grouping four houses, an education centre, administration, and a catering centre around a large central courtyard containing an outdoor recreation area. Additionally, there are indoor recreational facilities, including a swimming pool and a gymnasium.

The accommodation for the young people is single bedrooms with an ensuite toilet. There is a living/dining area, kitchen area, office, and a visitors/activities room in each house. Some houses also have additional sensory or games rooms.

Perimeter security is provided by the buildings and is supplemented by CCTV monitored by a designated team of operations staff.

The Care Inspectorate is a member of the https://www.nationalpreventivemechanism.org.uk/ - a group of organisations designated to monitor the treatment and conditions of those people who have been deprived of their liberty. This includes children and young people in secure care.

About the inspection

This was an unannounced inspection which took place on 24, 25, 26 and 30 September and 1 October 2024 with feedback given on 3 October 2024. The inspection was carried out by four 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 12 young people using the service
- spoke with 28 staff and managers
- observed practice and daily life
- reviewed documents
- spoke with visiting professionals.

Our inspection raised significant concerns in relation to how children and young people's health, welfare and safety needs were met. As a result, we issued the service with an improvement notice and an emergency condition notice on 4 October 2024. For further details of this enforcement, see the service's page on our website at www.careinspectorate.com.

Key messages

- Environmental safety, child protection and safeguarding were consistently compromised and meant young people were not being cared for safely.
- Young people were subject to, or witnessed, high levels of physical restraint and restrictive practice. We found that often the use of restraint was disproportionate to the level of risk presented.
- There was an absence of effective recording and reporting around risk management leading to a high risk of very poor outcomes.
- Staffing levels were at times dangerously low.
- All young people could identify a trusted adult in the service and we saw examples of compassionate care and support.
- We took enforcement action to require the provider to improve the quality of children and young people's care. Please see the service's page on our website for more information.

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?	1 - Unsatisfactory

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?

1 - Unsatisfactory

We were very concerned about several aspects of the care provided and we evaluated the service as delivering an unsatisfactory level of care for this key question. Due to the high level of concern, the Care Inspectorate took enforcement action and an improvement notice was served on 4 October 2024. As well as this, the Care Inspectorate issued an emergency condition notice which halts all new arrivals of young people until the requirements in the improvement notice are met.

Over the course of this inspection, we developed serious concerns about the safety of young people living in St. Mary's. Whilst some young people told us they felt safe, this was compromised by a number of fundamental issues. Environmental safety was consistently compromised and exacerbated by additional, unpredictable, system failures. We found door security regularly being breached by young people and failures by staff to appropriately secure the environment. This meant that young people were not safe (refer to improvement notice and emergency condition notice issued 4 October 2024).

Some staff we spoke with recognised the importance of relational safety, and whilst we found a workforce that wanted to protect young people, there was a level of complex need and risk that the staff were not resourced or consistently equipped to meet. Frequently, the number of staff on shift was not sufficient to meet the ratios identified in young people's support plans. The opening of five houses was made without sufficient analysis or adequate oversight of wider service capacity. This was felt acutely by young people living in the other houses and seriously compromised the care they received (refer to improvement notice and emergency condition notice issued 4 October 2024).

The opportunity to use preventative risk assessed practice was undermined by barriers to accessing key information. Staff were not equipped with crucial information to mitigate known risks and support young people safely.

We had serious concerns that young people in St. Mary's were not consistently and assertively protected from harm. The organisation's policy referred to national guidance and recently developed flow charts offered pathways to follow across a range of roles. However, we were concerned that despite these policies and processes now being in place, they were not sufficient to protect young people. Reporting to external agencies was inconsistent, at times delayed, and there was a lack of robust governance around child protection and safeguarding (refer to improvement notice and emergency condition notice issued 4 October 2024).

We found a disproportionate use of restraint and deviation from therapeutic crisis intervention (TCI). Young people were subject to or witnessed unnecessarily high levels of physical restraint and restrictive practice. The concerns already described, regarding compromised physical and emotional safety, were significant contributing factors to a culture that was reactive and resulted in restraint that was disproportionate to the risks faced. People had been harmed in the process of using restraint and there was no documented evidence to inform a culture of learning from significant incidents. We had significant concerns that the current workforce was not equipped to provide the therapeutic and stable care which matched the complex needs of the young people being cared for (refer to improvement notice and emergency condition notice issued 4 October 2024).

Young people had positive relationships with at least one trusted adult in the service, some had more. One young person told us: "I am respected most the time by staff, X is a legend [they] really care about all the young people." However, the potential positive impact of these relationships was undermined by the frequency of staff moves and changes to the rota. This made it difficult for staff to plan and commit to positive experiences for young people and also impacted on time in the community for those making progress. Uncertainty around who would be coming on shift or moving across campus created needless worry for young people.

Whilst there had been attempts to improve the environment, overall, the standards remained poor. The general living areas were stark, and dining facilities continued to be insufficient for everyone to sit together to eat. Bathrooms continued to be an area of concern where young people were living with crumbling plaster, badly stained silicone and toilet water running into bedroom areas from showers that caused damp smells. This was unacceptable and needed immediate attention.

There were some mechanisms in place to gain young people's views, such as the pupil council via education, the food committee, and recently young people had been involved in staff interviews. However, the amplification of young people's voices was undermined by a lack of timely, assertive and proportionate responses when they spoke out. This meant that when young people complained their concerns were not robustly investigated.

Partners in Advocacy had a consistent presence across the centre and staff welcomed young people's right to advocacy. As well as this, young people had access to responsible adults outwith the service.

We found some good assessment of young people's physical and mental health. When this was developed and shared collaboratively through multi-disciplinary working, this had a positive impact on young people's outcomes, but the potential positive impact for all young people was undermined by a lack of respect and value from staff towards each other's roles. This meant that opportunities to achieve the best possible outcomes were limited.

Some improvement had been noted around the development of medication policy and an audit process was now in place. However, young people remained at risk because outcomes from audits undertaken indicated there was a repeated pattern of young people not having their medication administered. This had not resulted in assertive action and investigation when reported to managers.

We found that young people were supported to maintain meaningful connections where it was safe to do so. When this was supported by skilled and experienced staff the impact was significant. The environment was not always conducive to family time because rooms could not facilitate this contact and there was a lack of space at other times.

We found some good examples of young people achieving in school and the structure and environment of school gave us some hope. We were concerned about the non-attendance of some young people and being expected to spend periods of time in their room during the school day. Care staff were not on hand to scaffold the education time and to work alongside education colleagues. This meant that some young people had interrupted access to education.

We found a poor standard of record keeping in general. The content of care plans was inconsistent and overall insufficient to guide good, outcome focussed care for all young people. There were repeated examples that, even when robust risk management plans were in place, this guidance was not followed, placing young people and staff at significant risk of harm. This was characteristic of the wider systems where staff were stretched and unable to focus on the fundamentals of safety. This created a significant

risk of harm for young people and staff (refer to improvement notice and emergency condition notice issued 4 October 2024).

Prior to this inspection, there had been significant change at both board and director level. This offered us some assurance about the service's capacity for improvement. We were assured that those tasked with governing the service had some understanding of the immediate need for improvement. The improvement notice gave leaders a clear directive for change.

Governance and quality assurance was a critical area of concern. The appointment of a temporary quality assurance advisor meant that some analysis had been undertaken around restraint, incidents and safeguarding. Additionally, the leaders had undertaken some very early quality assurance, evaluation and reporting focused on some of the identified concerns. External managers were also visible to young people in the service and young people told us this. However, the absence of governance meant inadequate oversight of the service's capacity and this needed to urgently change. The board and the director have accepted this and have given assurances that they will bring about the necessary improvements (see requirement 1).

The safety of the building, and respect for young people, was significantly compromised by dated facilities. Change had failed to be delivered at both the necessary pace and to correct critical areas of safety. This was exacerbated by the service continuing to be stretched and the continual arrival of young people with very high levels of risk and need. No analysis had been undertaken of what the service was equipped to safely deliver.

The numbers of staff deployed in the service was not responsive enough to meet the needs of all of the young people all of the time. We found times where staffing levels were dangerously low and managers had failed to govern the rota to ensure safety. This created unsafe situations where without the involvement of the police there could have been incredibly serious outcomes (refer to improvement notice and emergency condition notice issued 4 October 2024).

Safer recruitment was not being adequately followed. There was a reliance on new staff and more concerningly an over reliance on agency staff. We found critical concerns around unsafe practice from agency staff who had no induction. This meant that the safety of young people was compromised by ill-equipped and untrained staff (refer to improvement notice and emergency condition notice issued 4 October 2024).

We saw examples of compassionate care and support, and a core group of staff focused on undertaking therapeutic work with young people across care, education, specialist intervention services and catering. However, this was undone by the disconnect between these parts of the service and people failing to trust the strategies of others. This had created a culture of mistrust and young people's care was compromised by unclear models of care. It meant that people were not working effectively together.

Requirements

1. By 27 January 2025, the provider must ensure that quality assurance systems are implemented and used effectively to safely and consistently care for children and young people. To do this, the provider must, at a minimum, ensure that:

Quality assurance systems cover all the care practices and management actions necessary to both monitor safe care for children and young people and identify necessary improvements.

Areas of improvement identified by quality assurance processes are acted upon timeously and in a manner which reflects the importance of their impact on outcomes for children and young people.

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

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

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

Requirements

Requirement 1

By 14 December 2023, the provider must improve the reporting of all child protection concerns ensuring that all staff actions follow the service providers own policies which are in line with national guidance and best practice. This is to ensure that young people are protected and that investigation into concerns are robust and have appropriate external scrutiny and oversight.

To do this the provider must, at a minimum, ensure:

A) All child protection concerns, and allegations of abuse are notified in full and as soon as possible to the placing local authority, host authority local authority and to Police Scotland as per National Guidance for Child Protection in Scotland 2021 - updated 2023,

B) That robust quality assurance processes are implemented, with clear lines of responsibility for the oversight of the service child protection procedures,
and,

C) All child protection concerns, and allegations of abuse are notified to the Care Inspectorate as outlined in the document "Records that all registered care services (except childminding) must keep and guidance on notification reporting".

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SS1 2011/210).

This requirement was made on 17 November 2023.

Action taken on previous requirement
This requirement has not been met. We found no clear action plan to meet this requirement but found further evidence to increase our concerns in this area. This requirement has been incorporated into a new requirement as part of the enforcement action.

Not met

Requirement 2

By 14 December 2023, the provider must ensure that de-escalation strategies are person-specific and that that physical restraint is a means of last resort, and that young people are supported to regulate their emotions without physical intervention.

To do this the provider must, at a minimum, ensure:

A) All incident reviews and restraint analysis include review of de-escalation strategies and their effectiveness.

B) Incident reviews and restraint analysis take full account of the incident details and include reflective accounts of young people's views and staff debriefing.

This is to comply with Regulation 4(1)(c) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SS1 2011/210).

This requirement was made on 17 November 2023.

Action taken on previous requirement

This requirement has not been met. We found no clear action plan to meet this requirement but found further evidence to increase our concerns in this area. This requirement has been incorporated into a new requirement as part of the enforcement action.

Not met

Requirement 3

By 14 December 2023, the service provider must ensure there is continuous, robust evaluation of young people outcomes, experiences and their setting. All of this is underpinned through the implementation of high quality, SMART, care planning and risk assessment strategies.

To do this the service provider must,

• evidence a system of robust evaluations of young people's outcomes and experiences to ensure continuous improvement, support effective learning and meet young people's needs.
• ensure through these robust evaluation and quality assurance processes that plans are specific to young people's individual needs, having clear links to the formulations and reviewed for effective implementation.
• ensure that effective quality assurance exercises are consistently embedded across the service with clear lines of accountability identified. This should include routine oversight by the person responsible for the external manager role.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SS1 2011/210).

This requirement was made on 17 November 2023.

Action taken on previous requirement

This requirement has not been met. We found no clear action plan to meet this requirement but found further evidence to increase our concerns in this area. This requirement has been incorporated into a new requirement as part of the enforcement action.

Not met

Requirement 4

By 1 December 2023, the provider must show evidence of notifications to the Care Inspectorate as per the guidance document "Records that all registered children and young people's services must keep and guidance on notification reporting.

This is to comply with Regulation 4(1)(a)of the Scottish Care and Social Work Improvement Scotland (requirements for Care Services) Regulations 2011 (SSI 2010/2011).

This requirement was made on 17 November 2023.

Action taken on previous requirement
This requirement has not been met. We found no clear action plan to meet this requirement but found further evidence to increase our concerns in this area. This requirement has been incorporated into a new requirement as part of the enforcement action.

Not met

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

To ensure the safety of young people in the service the service provider should conduct a lessons learned exercise regarding staff actions that resulted in disciplinary measures. The service should draw up an action plan to address any actions identified.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which states that: 'Any treatment or intervention that I experience is safe and effective' (HSCS 1.24), 'I am confident that people who support and care for me have been appropriately and safely recruited' (HSCS 4.24), and 'My environment is secure and safe' (HSCS 5.17).

This area for improvement was made on 17 November 2023.

Action taken since then
This area for improvement has not been met. We have taken enforcement action at this inspection due to the significance of the concerns found. An improvement notice has been issued.

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?	1 - Unsatisfactory
7.1 Children and young people are safe, feel loved and get the most out of life	1 - Unsatisfactory
7.2 Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights	1 - Unsatisfactory

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