Allinvale House
Care Home Service

Airdrie

Type of inspection:
Unannounced

Completed on:
29 April 2025

Service provided by:
Love @ Care Ltd

Service provider number:
SP2018013216

Service no:
CS2020380030

About the service

Allinvale House is a care home service for children and young people. The service is provided and managed by Love @ Care Ltd.

Allinvale House operates out of two houses which are in the North Lanarkshire area. The service is registered to care for up to five children and young people, three in Allinvale House and two in Cromlix House.

The service provides accommodation which is spacious and consists of a range of communal and private spaces. Both houses also have a large living room, kitchen/diner with access to a garden and outdoor space. Young people have their own single rooms.

During inspection, two young people were living in the service on a full-time basis, and two further young people were in the service on a respite basis.

About the inspection

This was an unannounced inspection which took place on 9, 10, 11 and 14 April 2025. On-site visits took place on 9 April 2025 between 10.30 and 18:00, 10 April 2025 between 10:30 and 18:30, and 14 April 2025 between 9:30 and 17:00. 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 one young person using the service
- spoke with two family members
- spoke with 19 staff and managers
- observed practice and daily life
- reviewed documents
- spoke with six visiting professionals.

A serious concern letter detailing requirements surrounding environmental safety was issued to the provider on 10 April 2025, and was followed-up on 14 April 2025. Further details of this can be found within this report

Our inspection raised significant concerns in relation to how young people's health, welfare and safety needs were met. As a result, we issued the service with an Improvement Notice on 28 April 2025. For further details of this enforcement, see the service's page on our website at www.careinspectorate.com

Key messages

- The extent to which young people are protected from harm was compromised, as risks were not promptly identified or responded to.
- There were serious concerns surrounding environmental safety, and a serious concern letter detailing requirements surrounding these concerns was issued to the provider on 10 April 2025. Further details of this can be found within this report.
- Governance and oversight systems did not ensure young people experienced quality care support and protection.
- Unsafe medication practices compromised young people's safety.
- The service did not consistently implement adult and child protection procedures that followed best practice.
- Poor care planning, risk assessment and matching meant that young people's health and safety needs were not consistently met.
- Staffing arrangements and the mixture of skills did not meet young people's needs or keep them safe.

We took enforcement action to require the provider to improve the quality of children's / 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 aspects of the care being provided, and we evaluated the service as delivering an unsatisfactory level of care for this Key Question. Due to the service performing at an unsatisfactory level, we are concerned about the welfare, health and safety of children/people. We issued the service with an improvement notice.

The service had not equipped staff with the necessary skills to consistently identify or respond to indicators of concerns to ensure safety for young people. As a result, young people's safety was compromised. (Refer to improvement notice issued on 28 April 2025).

Environmental hazards were not promptly identified or addressed, which resulted in increased risk to young people. As a result of the potential risks to young people's safety and wellbeing, we issued a serious concern letter to the provider on 10 April 2025. The letter outlined the immediate improvements we required the provider to make.

A further visit to the service was carried out on 14 April 2025, to evaluate whether improvements had been made. We evaluated that aspects of this requirement had not been met. (Refer to improvement notice issued on 28 April 2025).

Young people's safety was compromised as a result of the medication practice within the service, and we found unsafe practice around medication handling, administration and recording. (Refer to improvement notice issued on 28 April 2025).

Young people had access to advocacy and external professionals visited the service on a regular basis. However, we heard that communication had been poor, and proactive interagency working had not always been prioritised. This meant that external networks did not always provide the safeguards required.

National guidance and best practice in child protection and adult support and protection was not consistently followed. This approach did not ensure young people's safety. Incident reporting and debriefing was inconsistently recorded. We could not be assured that risk management, including restrictive practice, followed best practice or that young people would not be unnecessarily subject to restrictive practices. (Refer to improvement notice issued on 28 April 2025).

Children and young people had not consistently experienced stable care. The extent to which children and young people's needs were met was limited, because personal planning and risk assessments did not capture all the identified risks or consistently provide staff with helpful support strategies.

We found that staff were caring, and we found some positive outcomes for young people in the care of Allinvale House. However, there was a lack of understanding around trauma and the impact this might have on young people's behaviours and development. This meant young people did not always receive support that was sensitive or compassionate.

The facilities and resources did not reflect the wide-ranging needs of young people. This meant they were not fully respected.

Staff had worked hard to develop trusting relationships with some family members, which supported transitions for those young people who used the service on a respite basis.

The culture in the service did not value personal planning and risk assessments, or consistently use this to guide practice. As a result, the support offered to young people to build on their individual strengths and skills was impacted. (Refer to improvement notice issued on 28 April 2025).

We were not assured that managers effectively contributed to keeping children and young people safe and improving outcomes. We did not see evidence of the quality of care and practice being effectively monitored.

We found that the presence of managers across Allinvale House and Cromlix House was inconsistent. There was also a lack of clarity around their roles and responsibilities. This led to confusion for staff members and contributed to a lack of accountability for oversight and governance in the service. (Refer to improvement notice issued on 28 April 2025).

The service had not always carried out assessments to ensure young people could safely live together. Assessments that had been carried out did not fully consider the risks, vulnerabilities, and needs of young people, or how the service would manage these. As a result, staff told us that they relied on controlling the movements of young people to safely manage risks. This contributed to unnecessary upset or trauma for young people.

Staffing arrangements and the mixture of skills did not meet young people's needs or keep them safe. There was a lack of consistency and continuity, which limited children and young people's ability to build trusting relationships.

Staff were not individually equipped to successfully meet all the needs of young people. Staff had not received training specific to the individual needs of young people. Staff told us they often did not know how to respond to young people's risks or needs. This resulted in inconsistent care and practice.

Leaders did not offer consistent support and supervision to ensure staff felt confident and valued in their role. Young people did not benefit from well planned and skilled trauma informed interactions. There were some systems in place to monitor aspects of service delivery and the quality of the setting, but they were largely ineffective. The oversight of leaders was not effective, and this impacted on the capacity of staff to support young people. (Refer to improvement notice issued on 28 April 2025).

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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