Review of compliance

Treloar Trust Treloar College	
Region:	South East
Location address:	London Road Holybourne Alton Hampshire GU34 4EN
Type of service:	Doctors consultation service Care home service with nursing Specialist college service
Date of Publication:	January 2012
Overview of the service:	Treloar College is a term time residential further education establishment for up to 163 students with physical and, or learning disabilities. There are five residential houses and independent living flats on the campus and these are registered to provide

	personal care only for the students twenty four hours a day. The campus is large with varied facilities and is a short distance from the market town of Alton.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Treloar College was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited this service on the 11 May 2011, and then carried out further visits on the 15 and 16 June 2011 and the 4 July 2011.

The students we spoke with told us they liked being at the College and they could speak to the staff at any time if they had any concerns. Students said they generally got the care they needed, although some said the staff ,did not always remind them or support them with all aspects of their care.

Two students said the staff were rushed sometimes and could not always spend enough time on their care.

Students said they felt safe at College and they knew who to speak to if they did not feel safe.

The students told us about the activities they enjoyed and the opportunities they had for socialising and seeing their families.

The staff said there were enough people on duty to meet the students' needs and they had the training and support they needed for their roles.

A relative told us they were concerned about several aspects of the care including the number of staff available to carry out care, the standard of care and how this had led to their family member suffering harm and how the staff care for their family member's clothes. This relative also told us they have made a complaint to the College about the care of their relative.

The local authority told us that there was a lack of communication between different staff at the College which has led to students not receiving the care they need, and a lack of accurate records and risk assessments that reflect the students' needs.

What we found about the standards we reviewed and how well Treloar College was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

We found the students were at risk of receiving unsafe or inappropriate care because the planning and delivery of care does not meet their needs.
The care plans do not include all of the students' needs and the lack of communication between different care staff around the college means that the students' care needs are not coordinated or kept up to date.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The students are not protected against the risk of abuse because the college has failed to report and respond appropriately to allegations or concerns.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The College is failing to maintain appropriate standards of cleanliness of equipment. The inadequate cleanliness of the wheelchairs means the equipment is unpleasant for the students to use.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Treloar College is failing to protect people who use the service against the risks associated with the unsafe use and management of medication.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

We found that although the students felt one of the houses meet their needs, not all of the fixtures and fittings are in good repair.

Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

We found the College is failing to protect the students because they are not operating safe or effective recruitment procedures when they use staff from an employment agency.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

We found that although there are enough staff to meet the students' care needs, the provider has found it difficult to recruit enough staff to offer any extra time above the basic care that students may require.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

We found the students are not being protected against the risk of inappropriate or unsafe care because the system for regularly assessing and monitoring the quality of the service has not identified inadequate practice. The staff responsible have not taken the actions to address any failures until outside agencies have brought these to their attention. We found that the College has not identified risks relating to the health, welfare and safety of the students.

Overall, we found that the service was not meeting this essential standard and

improvements are needed.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

We found that we are not always notified of events or incidents without delay, so the students cannot be confident that important events that affect their welfare are reported to us. If we are not notified, we are unable to take any necessary actions.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We have taken enforcement action against Treloar Trust.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We asked seven students about their care and whether they enjoyed being at the College. The students told us the staff understood their care and they added that the staff usually asked them when and how they preferred their care to be given. Several students told us they were able to direct their own care and tell the staff how they wanted care carried out.

The students said the staff had asked them about the care they needed and then explained what was written in their care plans, they added that they had signed to agree with these plans. The students said they had review meetings to discuss their care and they could invite their families. We saw that students had signed to agree to their care plans.

Students said the staff were 'nice' and they could ask or talk about their care with the staff at any time.

One student told us the staff checked to make sure they did not become sore by sitting in their wheelchair for too long and the staff helped them to move regularly.

Another student told us that although they needed to wear a piece of equipment every day, sometimes they forgot and the staff did not remind them.

One student requested to speak to us during our visit on the 16th June 2011. This

student raised concerns that they had. This student also told us they were representing a small group of students because they could not all see us as they were attending classes.
This student said that recent changes to the way medication was given meant that they had to queue up for a long time. The student said that some staff from the campus houses used to be able to give certain medication but now this had stopped and this meant that their medication took longer. They said 'there are too many new rules which are not common sense'. They said they 'understood people needed to be safe but the new system was going too far'.

Other evidence

During our visit on the 11th May 2011, we saw three care plans, these contained details about each student's care and routines but they did not include all the care needs. The plans were personal to each student and they guided the staff about how to carry out care in a way the student preferred.

We saw that risk assessments relating to the care and welfare of students, care of their pressure areas and manual handling had not always been completed, therefore it was not possible to determine whether full risk assessments had been carried out. There were no assessments in place for the risk of choking on drinks even though the staff told us that no students had drinks whilst in bed due to this risk.

On the 15th June 2011 we saw three further examples of care plans. These had personal details about care and people's preferred routines from when they got up to when they went to bed. There was some detailed guidance for staff about care tasks including specialist feeding.

On the 4th July 2011 we saw one more care plan. This had a daily routine and how the care should be carried out.
The provider's self-assessment stated there was close involvement between all the staff who worked with the students in different areas of the college.
However, we found examples of students needing care that had not been included in the care plans. We also found examples where care had been provided by staff on the college campus but details had not always been included in the care plans at the students' campus houses. These examples had led to students not receiving the care and treatment they needed. An example of this is on the 5th May 2011 a student asked for some cream as they were sore. The care records stated that, on the 6th May 2011, cream was applied and the student was indeed sore. There was no record to indicate the student had been checked or received any treatment on the 7th or 8th May 2011. On the 9th May 2011 the record stated the student was still sore and there was none of the right cream available so another cream was used. The records did not demonstrate that the student was seen by any medical staff, and there was a delay of two days when the student appeared not to have received care or treatment.

A relative of another student told us the student had suffered a number of infections and the relative felt this was because staff were not ensuring the student was kept clean. This relative also told us they were concerned that the student returned home with sores in two different areas of their body. When the relative enquired with staff at the College, the staff said they did not know when or why these sores had occurred. This relative told us their family member had two skin conditions and the student

returned home with inflamed areas and again the staff could not offer explanations of why these were not being checked or treated. This relative was also concerned that the staff were not helping the student with other care tasks such as ensuring their toothbrush, and hairbrush were kept clean. The relative said the staff had not helped the student to keep their nails or hair in reasonable condition.

On the 4th July 2011, we found there were records in the health centre about this student being sore and that creams had been applied. The staff told us that they knew this student had sensitive skin and they made sure they helped the student to stay clean and dry. The daily records did contain information that the staff had ensured this person's skin was kept dry.
The student told us they directed the staff to keep them dry and sometimes the staff seemed too rushed to help them properly.
The staff explained why the student may get sore skin and what was done to help the student. The care plan had some guidance for staff about this student's skin but there were no assessments of the student's two skin conditions or how the staff should be checking the skin condition or reporting if these deteriorated.
During our visit, we saw that the equipment the student had in their room, such as their toothbrush and hairbrushes were clean. The student said the staff helped them with their hair. The staff said the student's relative helped the student to apply their chosen hair colour when they went home. Two staff told us that sometimes they carried out nail care but the student also chose to use a regular visiting nail care service for their finger nails.

The house manager, we spoke with, told us they had found that some aspects of care that students needed had not been included in the care plans. When we asked about the lack of information in the care plan regarding the needs of one student, the manager said it was the student's responsibility to use a piece of equipment they required each day. However, the manager then said the student could not be expected to always remember and they would always require staff assistance to use the equipment.

We found another example of care not being recorded. One student's care plan recorded that their skin should be checked daily as they were at high risk of developing pressure sores. We found that the pressure sore risk assessment had not been completed. The manager of the house told us the risk assessment was relevant to this student and it should have been completed. The manager also told us the staff had been given guidance several months ago to check that information in the care plans relating to pressure area care was correct. We asked the manager to review the daily notes for one day and we checked the notes for two other days, and found no record that this student's skin had been checked.

We found a lack of communication between staff in different areas of the college meant that students had not received the care they needed and, in one instance, this had put a student's health at risk and meant they had been uncomfortable for a number of days.

We have seen the minutes from a Hampshire local authority safeguarding meeting relating to one student in March 2011. These minutes recorded that failures of care and communication at the College had put the student at risk and their condition had deteriorated. The minutes stated the lack of coordinated care and communication had led to this deterioration.

On the 15th June 2011, we found a further example of a lack of communication between staff in different areas of the college. A care plan contained information about a student needing some specific exercises. The information specified these should be carried out at least once a day to prevent their medical condition deteriorating. The staff at the house were unclear if they should be doing these exercises with the student. There was no evidence in the daily records to indicate they had been completed.

The lead physiotherapist told us the student did not require these exercises daily, but their assessment had not been passed to the house care staff. They said the staff in the house could use the exercises guidance that was in the student's care plan with the student. The house manager confirmed the student did need these exercises. The care plan had a chart to record when they were carried out. We saw this chart had not been completed.

The lead Physiotherapist told us that the staff in the therapy centre did the exercises whenever they could but they were only funded for a certain time each week per student. They added that if someone else needed more urgent care, the student's exercises would not be done, but the student did have hydrotherapy or other exercises. The student told us they needed the exercises or their condition got worse. The staff in the house did not know about these exercises and they said they had not been instructed in how to carry them out. The lead Physiotherapist said they would be happy to show the staff how to do these exercises with the student if the staff had time.

We saw this student's physiotherapy assessment. The assessment was incomplete and the lead Physiotherapist told us they did not always need to complete the assessments and there was no system for sharing information with the care staff in the student's house.

An action plan dated March 2011 had been agreed between the local authority and the college, following recent safeguarding cases, which identified how improvements should be made. One of these actions included ensuring the staff communicated the needs of the students and any changes to their health or wellbeing between different areas of the college. These changes should have been included in the care plans so all staff could offer the care that was needed. We found this had still not been put into practice by the date of our visits on the 15th and 16th June 2011.

The staff were able to describe the care each student needed, but they also told us that not all of the care was recorded in the care plans. Staff said they had to be assessed as being competent in each area of a student's care before they carried out the care unsupervised. The staff said they recorded the daily care they gave and this included when they moved a student to prevent pressure sores. The daily records did contain details about the care that staff had provided and this included a record of when staff assisted a student to move position.

Our judgement
We found the students were at risk of receiving unsafe or inappropriate care because the planning and delivery of care does not meet their needs.
The care plans do not include all of the students' needs and the lack of communication between different care staff around the college means that the students' care needs are not coordinated or kept up to date.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The students told us they felt safe at the college and they knew who to speak to if they had any concerns.

Other evidence

The staff told us they had been trained in how to handle safeguarding issues. The training records we saw confirmed that staff had received training every two years. The staff were able to describe the actions they would take to report any concerns to their line managers. However, we found the staff had not always followed the procedure to protect the students.
One example was where the staff reported concerns on a Friday about one student but no further action was taken until the safeguarding officer came back to work on the following Monday. This should have been reported to senior staff straight away and the staff should have ensured that actions were taken to protect the student. As a result, this left the student at potential risk over the weekend.

We had been made aware by the local authority of three recent safeguarding incidents since the visit on the 11th May 2011 and there had been five incidents between December 2010 and March 2011. Not all of these incidents had been reported correctly and in some instances there had been an unnecessary delay in reporting to the local authority.

The local authority had told us they were concerned about the way the service had

failed to manage safeguarding incidents or allegations correctly.
The local authority also told us that, during one recent safeguarding meeting, senior college staff had reported another serious incident but these staff had not reported it or responded correctly at the time of the incident.

The college had their own procedures for protecting the students and reporting and responding to concerns but these had not always been followed and the actions of staff had put some students at potential risk. On the 16th June 2011, the College Principal gave us a copy of a guidance document for staff, entitled 'Safeguarding (Child/Vulnerable Adult recognition of Abuse and Protection) Guidelines' numbered Policy B8 and first published in October 2001. This policy had been revised in September 2009 and again in March 2010. This document gave College staff guidance regarding how they recognise, respond to and report suspected abuse whether through witnessing an incident or being told information by a student, a colleague or any other person.

On page 3 of the guidance under section 1.2, staff are told they report any written details by using a safeguarding referral form and passing the information to the residential manager or the safeguarding officer.

During our visit to the College on both the 11th May and the 15th June 2011, we asked four staff about their understanding of their responsibilities regarding protecting the students from harm or abuse. The staff described how they would respond and all staff we spoke to said they would act according to the procedure and contact the safeguarding officer.

The guidance stated that the staff should contact the safeguarding officer or senior staff during the day or the safeguarding officer or the nominated individual during the night. We found that in practice the safeguarding officer had told all staff they were to be contacted 24 hours a day. The College Principal told us she was surprised when she found this out as this was against College policy.

This meant that staff were not following the guidance and this had caused delays in referrals being seen by any senior staff or any action being taken to refer reports to the Hampshire adult services safeguarding team, because when the safeguarding officer was unavailable referrals waited until she returned to work. The safeguarding policy (B8) states on page 27 that staff should take immediate action regarding dealing with emergencies and contact emergency services but only senior staff should refer to the Hampshire adult services safeguarding team within 24 hours and reasons for any variation to this timescale should be recorded.

An example of the College's failure to apply the policy correctly or to act to protect a student is that a referral was made to the safeguarding officer and no other senior staff on the 10th June 2011. This referral recorded that a student had shown signs of depression and told staff that because they did not want to leave college they 'might as well end their life'. The safeguarding officer did not see this referral until the 13th June 2011 as they had been unavailable that weekend. On the 13th June 2011, the safeguarding officer contacted the College house to ensure the student was supported and then made a referral to adult services on the 15th June 2011. On the 15th June 2011 the CQC inspectors asked the safeguarding officer why there had been a delay, and the officer stated 'the staff in the house would have taken action over the weekend'.

There was no evidence to demonstrate any action had been taken between the 10th and the 13th June 2011.

The safeguarding officer told us she was responsible for training the staff regarding safeguarding issues. The safeguarding officer was unable to describe any actions they had taken to follow this incident up with further staff instruction or guidance, so the staff could be clear about how to respond and report concerns in future to prevent delays in reporting if the safeguarding officer was unavailable.

The College supplied us with a flowchart which staff used to guide them in how to respond to and report safeguarding concerns. This flowchart stated if students are not in immediate danger, the staff should contact the on call manager at night or the safeguarding officer or other senior staff during the day. If students are in immediate danger, the flowchart advises staff to contact the safeguarding officer or the nominated individual if the safeguarding officer is unavailable. On the occasion above where a student was indicating suicide, a safeguarding referral was made on a Friday and no action was taken until the Monday. Therefore staff failed to follow the procedure.

The policy stated on page 3 that staff must make as detailed a note as possible but they must not delay in reporting information to the safeguarding officer. However on the 15th June 2011, the safeguarding coordinator told us that sometimes staff reported concerns verbally and a form was not completed.

On the 15th June 2011 a student made serious disclosures about possible abuse at their family home. We asked the safeguarding officer about this as the student told us they had told staff. The safeguarding officer was aware of the concerns and showed us three completed referral forms and one handwritten note relating to this student dated the 14th September 2010, 13th October 2010, the 18th November 2010 and the 13th December 2010. The safeguarding officer had contacted the student's social worker, but they had not followed up what actions had been taken and they had supported the student to contact the family member who the student had reported being 'scared of'. The student had continued to be sent home to a potentially abusive situation during College holidays.

On the 16th June 2011, this student spoke to the inspector again. The student asked for their college tutor to be present. The student repeated their allegations of abuse at home. The tutor told the inspector they were aware of a previous allegation that had been made by this student but they did not realise the alleged abuse was continuing. The tutor then asked the inspector how they should respond and what they should do. The inspector advised the tutor to follow the College's internal procedures.

The tutor gave a written report to the nominated individual on the afternoon of the 16th June 2011 while the inspector was continuing the compliance visit. When the inspector reviewed this written safeguarding referral, we found that this was not an accurate description of what the student had said and the tutor implied the abuse was historical and not still happening. The student had told the inspector and the tutor that the abuse was continuing at home. This demonstrated that, although the staff told us they understood the safeguarding policy, it was not being used correctly in practice.

On Page 27 of the policy 7.2 Information for Care Providers, the policy stated that

'within 24 hours key staff must consider the risk issues and record this assessment'. In the case above there was no record that either of these actions were taken after any of the three safeguarding referrals or after the record of the safeguarding officer speaking with the student involved on the 13th November 2010.

On the 16th June 2011, the College Principal told the inspector they were not aware of these concerns and the safeguarding officer had failed to follow the policy or protect the student.

On June 21st 2011, Hampshire Adults Services told us that the College Principal had informed adult services verbally about the concerns regarding this student. Prior to this, the College had failed to inform Hampshire adult services safeguarding team about the four other occasions when the student expressed concerns. Adult services told us they would expect to be informed and made aware of the concerns although the local authority for the student's home area would have taken the lead in any safeguarding investigations.

Hampshire Adult Services at the Local Authority told us during a meeting on the 31st May 2011 that the registered person had not responded appropriately to another separate allegation of abuse from a different student. On one occasion, staff from the location had 'mentioned' a very serious allegation during an unconnected safeguarding meeting, at Adult Services, some time after the alleged incident occurred. No safeguarding alert had been sent to the local authority. By not alerting the authority, staff at the College were failing to follow their own safeguarding policy B8 and failing to protect the students from the risk of harm or abuse.

Following the subsequent investigation of this case by the local authority, we were told at a safeguarding case conference that the College had failed to respond to and report their concerns, as staff had assumed that the abuse could not have happened due to the disability of the student involved. This incident was also not notified to CQC until 10 days after the incident was alleged to have taken place.

The College Principal employed an independent consultant to work with the safeguarding officer in the week commencing 6 June 2011 for three days, and as a result, they produced a guide for managers for when suspected abuse was witnessed or disclosed. This guide had not been distributed to the managers by the time of our visit on 16th June 2011. When we spoke to the safeguarding officer during our visit on 16th June 2011, they told us they were unsure if this guide had been distributed to the staff. The safeguarding officer told the inspectors that the managers who received the guidance would sign to say they had read it. The safeguarding officer told us they were unaware of any arrangements to ensure the guidance was understood and implemented.

As a result of the above, we had concerns that although there were some suitable arrangements in place to ensure that students were safeguarded against the risk of abuse, staff were not taking reasonable steps to identify the possibility of abuse and prevent it before it occurred nor were they responding appropriately to some allegations of abuse. As a result, this was placing students at Treloar College at considerable risk of harm to their health and welfare.

Our judgement
The students are not protected against the risk of abuse because the college has failed to report and respond appropriately to allegations or concerns.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

We did not, on this occasion, speak with people who used the service so cannot report what they said.

Other evidence

We did not plan to review this outcome but during the visit on the 11th May 2011, we became concerned about the cleanliness of some pieces of equipment at the college. We saw that a number of wheelchairs were unclean. These were both wheelchairs being used by the students and those unused and being kept in a store room. The wheelchairs in the store room were either spare wheelchairs or having their batteries charged up.

We saw dust, dirt and debris on the wheelchairs seats, frames and arm rests. We asked the manager of one of the houses about this. The manager told us the wheelchairs were not part of any cleaning routines but there was equipment available to clean them. The manager said the students were responsible for making sure their chairs were clean and telling the staff if they needed support to clean the wheelchairs. The students often had profound disabilities and they used their chairs daily but would be unaware of the cleanliness of the wheelchairs. When we discussed this with the manager, they confirmed that many students would not be able to see the areas of the wheelchairs that required cleaning. The staff told us they would clean a wheelchair if they noticed it needed cleaning.

We found a large number of wheelchairs in a store room during our visit in May. The manager explained these were spare wheelchairs or stored whilst their batteries

charged. These wheelchairs had dust, dirt and food debris on them. The manager showed us equipment in the store room that staff could use to clean the wheelchairs but this had not been used because we observed the wheelchairs remained dirty.

We looked at the wheelchairs in a different house at the College during our visit on the 15th June 2011 and found the wheelchairs did appear clean, although understandably they had mud splashes as it had been raining hard. The staff could not show any evidence that a cleaning schedule had been introduced as a result of us raising concerns following the last visit on the 11th May 2011. This had been recorded as an action for improvement in the action plan the College Principal sent to us following the last visit.

A relative told us that when they collected their family member from the College the wheelchair was 'filthy' with food and dirt. The relative said this was still happening after the time the College had been informed by us that the cleanliness of wheelchairs was a concern.

On the 4th July 2011, we noticed another wheelchair in use that was very dirty in all areas. Two staff told us they cleaned the chairs when they put them on charge in the evenings. The two staff and the manager were unable to describe any system for ensuring the wheelchairs were kept clean or for monitoring their cleanliness.

The manager of one of the houses was aware of the Heath and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance and they had identified a member of staff as the lead person responsible for ensuring the code was followed by the care staff.

Our judgement
The College is failing to maintain appropriate standards of cleanliness of equipment. The inadequate cleanliness of the wheelchairs means the equipment is unpleasant for the students to use.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Students told us they had their medicines in their rooms and the staff helped them to take their medicines. Other students said they were given their medicines by the staff and this was 'all right.'
Students said there were no problems relating to their medication.

Other evidence
Staff told us that the students were assessed and they supported them if they wanted to take control of their medication.

We found an assessment was available in the individual care records of the students who were assessed to administer their own medicines. We observed that the tablets were kept locked in the residents' bedrooms and the residents retained the keys. For a student who was assessed as self- medicating, there were written instructions in their rooms of how the care staff would help them to administer their medicines. This instructed the staff 'to place my tablet on a teaspoon and place the tablet at the back of my tongue.' It also stated that 'I have some other medication that needs to be signed for'. However, the staff had not signed when they had assisted one student to take their medication. The senior staff confirmed that when staff assisted students who had been assessed as able to self medicate there was no system for the staff to record what medication had been taken.

We also found that when a medicine had been prescribed to be given 'as required'

(PRN) there were no records to demonstrate how or when staff decided to give these medicines safely and consistently and no place to record that they had been given. There were no care plans to say how, why or when these medicines should be used for each student who required them.

We noted that one person had been prescribed a painkiller to be given three times a day. This was not recorded on their medication chart. Staff told us that the student did not require this regularly; however they would give these as required.

We found that there were some prescribed medicines for individual residents that staff confirmed belonged to certain residents but these were not labelled correctly. Other items were kept with the students' medicines but these items had no labels and they were not included on the charts.

The staff said they had not had any training in the safe use of medicines but they were supporting students to take their medicines. The training information supplied by the College did not include training for staff regarding the safe administration of medication.

One student needed to have their health monitored monthly because of the medication they were prescribed, but despite being prescribed this medicine for some time, only one test had been carried out.

The care staff and other staff at the College were unclear about where records should be kept relating to health and medication and who was responsible for making sure the care plans were kept up to date and for communicating changes in the care or welfare of the students.

On the 16th June 2011 we found the College had employed two consultants to temporarily manage the medication system and the more complex needs the students had. One of the consultants told us they were working with the college staff to improve the systems for medication.

We saw the medication records (MAR charts) for six students. We found frequent gaps where medication had not been recorded as given or refused. For one student's records between the 6th June 2011 and the 16th June 2011 there were gaps on five occasions. For another student's records between the 9th June 2011 and the 13th June 2011 there were five occasions when there was no record to say if that student had received their medication. We found on two occasions that medication should have been given at regular intervals, such as every three days. The days these were signed for varied and on occasions the gaps were more than three days apart. This meant students were not getting their medication as prescribed.

The College promotes the students' independence and staff told us that sometimes students refused or did not arrive at the health centre for their medication. Staff told us there were no risk assessments and no system for checking where students were or to remind them of the consequences of not taking their prescribed medication.

One student was prescribed two types of pain killers. We saw that on the 6th June 2011, they had received both types at the same time and the consultant stated that this was a drug error and should not have been given. There was no incident form to report this incident. We also found there were no protocols that gave staff guidance about

when they should give 'as required medication' (P.R.N). When these medications were given the staff were recording in an incorrect section of the medication record charts. The medication charts did not indicate when a drug was prescribed and started to be given to a student. This also meant that the staff would be unable to monitor when any medications should be reviewed.

Our judgement
Treloar College is failing to protect people who use the service against the risks associated with the unsafe use and management of medication.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us

The students told us the College houses suited their needs.

Other evidence

We saw that one of the houses had areas that were very worn and had damage to door frames. The manager of this house said there was an ongoing programme of repairs and decoration.

We noted that some doors and corridors had a special covering to minimise wheelchair damage. The house appeared 'shabby' in some areas such as in a common room and the corridors, but the students said it was the oldest house on the college campus and they liked it the way it was. The house manager showed us areas of the house that had been painted recently.

Our judgement
We found that although the students felt one of the houses meet their needs, not all of the fixtures and fittings are in good repair.

Overall, therefore, we found that there are areas of non compliance with this outcome.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are moderate concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

We did not, on this occasion, speak to people about this outcome area so cannot report what people said.

Other evidence
A sample we reviewed of the staff recruitment files during our first visit demonstrated the College had followed safe recruitment procedures for staff they had directly employed. The recruitment check details were kept at the central office and the providers made this information available when we asked for it.

We asked to see records for staff supplied by an unregistered employment agency. This was because the local authority had told us about concerns with a member of staff supplied to the college by this agency during a safeguarding investigation. We were told that the agency staff brought a one page sheet with them when they came to work and this had details that indicated they had had the necessary checks before being employed. We saw an example of these sheets during our visit. However the provider had not verified these details. Therefore, the providers were unable to demonstrate that they had assured themselves that these staff had been recruited safely by the agency.

The providers sent us a letter after the visit to show they had taken action and were no longer using the agency. However we have not tested whether the provider is now following safe recruitment procedures to protect the residents since the visit so cannot confirm they are compliant at present.

Our judgement
We found the College is failing to protect the students because they are not operating safe or effective recruitment procedures when they use staff from an employment agency.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The students said that if they needed to call for staff using their call bells, the staff came to them quickly and they rarely had to wait long.

Other evidence
The provider's self-assessment stated that there was a house manager as well as a deputy manager and unit leaders available in each house. The provider's self-assessment declared non -compliance because the College had found it difficult to recruit enough staff.

The College told us they intended to address this by reducing the number of full time residential students and by continuing to recruit new staff. The College stated that they would address any staffing issues by September 2011.

Since the visit, senior staff told us that, in the last year, more students than anticipated had attended the College and there were enough staff to meet the students' needs. However, they told us there were not always enough staff to provide extra time that the students may require.

The staff we spoke to during the visit said that were usually enough staff to meet the students' needs unless staff went off duty due to ill health. The staff said they worked well as a team and they made sure there were enough staff at all times. The staff worked consistently in one house on the campus so they said they got to know the students well. The staff had a minimum of nine training days per year and the training

records confirmed this. A member of staff told us that they could always ask the other staff if they were unsure about how to provide the care a student needed and the senior staff were always helpful.

One relative told us there were not always enough staff and the staff were rushed when they provided care, which did not suit their family member's needs. They gave an example when they told us that on occasions their family member had been helped to bed at 11.30pm because there were not enough staff to help the student when they wanted to go to bed at around 9pm. This relative said that on at least one occasion there had not been enough staff to help their family member get up before 8.30am and they still needed to have breakfast and get to College classes by 9.00am. This relative said that their family member told them there were not enough staff to spend time and comfort them when they were upset or needed company.

The action plan referred to earlier and developed by the College in agreement with the local authority stated that the College would continue to review the staff skills and training needs.

The provider's self-assessment stated that the College employed a number of specialist staff to support the students. We saw records that demonstrated that the students had access to physiotherapy and occupational therapy services.

Our judgement
We found that although there are enough staff to meet the students' care needs, the provider has found it difficult to recruit enough staff to offer any extra time above the basic care that students may require.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The students said they have lots of opportunities to give their views about the service. The students said they can go to the regular house meetings, or they can speak to the staff at any time. The students told us they have surveys they can complete and there are ways of suggesting improvements.

Other evidence
We did not plan to review this outcome but during the review we became concerned that the providers were not compliant.

We found that different senior staff who had responsibilities for different areas of the college were unaware of some of the concerns that could put the students at risk. These included the lack of adequate or safe medication procedures and the inadequate planning and delivery of care.

The college employed a number of senior staff who were responsible for different aspects of the students' care and welfare. These staff had a duty to audit and monitor the quality of the care and to report to the College Principal. The senior staff had not always carried out this duty and therefore action had not always been taken to address failures in the quality of the care and issues had not been escalated accordingly.

We saw a sample of the risk assessments for students. These assessments were meant to identify any risks and guide the staff in the steps to take to minimise those risks without unnecessary restrictions on the students' daily lives and choices. The risk

assessments were incomplete and they did not contain the guidance the staff needed. The care plans had details of some risks but the risk assessments were either partly completed or not used. A senior staff member told us after the review that they had found different risk assessments being used in different areas of the College and these did not give a consistent guide to the staff.

During a meeting with the Principal they told us that they had been informed by senior staff that audits had been carried out and no concerns had been found. The Principal also told us that they had recently carried out new audits that had shown similar concerns to those we had raised as part of the review.

Our judgement
We found the students are not being protected against the risk of inappropriate or unsafe care because the system for regularly assessing and monitoring the quality of the service has not identified inadequate practice. The staff responsible have not taken the actions to address any failures until outside agencies have brought these to their attention. We found that the College has not identified risks relating to the health, welfare and safety of the students.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are major concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us

We did not, on this occasion, speak with people who used the service so cannot report what they said.

Other evidence
During this review, we looked at all the information we held regarding notifications made by the College to CQC.

We found there were 18 incidents for which CQC should have received notifications between the 19th January 2011 and 17th June 2011. Of these, we had received notifications for 13 of the 18 incidents. We know this because we analysed the information that the College had sent to CQC and compared this with information we had been given by the Local Authority, during safeguarding meetings, about notifiable events where we should have received notifications. Therefore the College failed to notify CQC on 5 occasions.

The regulations (18.1 Paragraphs 3 and 4) require that Treloar College notifies us without delay. We define 'without delay 'as straight away and certainly within 48 hours of any notifiable incident for cases of suspected abuse. We found that, of the 13 notifiable events, the College sent to CQC, 20% were sent within 48 hours, and 80% were reported later than 48 hours. Of that 80%, 50% were sent within 5 days of the incident and 50% were sent after 5 days.

In a copy of the safeguarding minutes sent to CQC from Hampshire Local Authority dated the 25th February 2011, it was noted that a student had developed grade 4 pressure sores, noted by staff on the 6th December 2010. This would meet CQC regulation 18 as a notifiable incident because it constituted an 'injury to a service user' which CQC needed to be notified about in case any regulatory action was required. A notification was received on the 23rd December 2010, which constituted a delay of 18 days.

Another example was an incident where an agency member of staff had inappropriate contact with a student. This incident occurred on the 5th February 2011. The College staff completed a notification on the 26th April 2011 and this was received by CQC on the 3rd May 2011. This meant a delay of 87 days.

As part of the review visit on the 16th June 2011, we spoke with the Principal regarding the system for notifications being forwarded to CQC. We also asked the nominated individual to describe the system for reporting notifications. The nominated individual told us she was the only person at the College who was responsible for collating and dealing with notifications. She described the way staff passed incident/accident forms to senior staff and then to herself. She said that the forms were scanned and sent to relevant people within the College and that the Principal signed off all incident forms but this may be some time after the incident occurred.

On the 15th and 16th June 2011, we visited the College and during those visits, a student disclosed an allegation of abuse to the inspectors. The student said they had previously informed College staff. The inspectors found that the College staff had safeguarding referral forms dated the 14th September 2010, the 13th October 2010 and the 13th December 2010, as well as a note written by the safeguarding officer dated the 18th October 2010. These were serious notifiable incidents that had been reported to the College on three occasions since CQC had registered the College under the Health and Social Care Act 2008, but CQC did not receive any notifications from the College about these allegations.

Our judgement
We found that we are not always notified of events or incidents without delay, so the students cannot be confident that important events that affect their welfare are reported to us. If we are not notified, we are unable to take any necessary actions.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation and nursing or personal care in the further education sector	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: We found that although the students felt one of the houses meet their needs, not all of the fixtures and fittings are in good repair. Overall, therefore, we found that there are areas of non compliance with this outcome.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation and nursing or personal care in the further education sector	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: The college is failing to maintain appropriate standards of cleanliness of equipment. The inadequate cleanliness of the wheelchairs means the equipment is unpleasant for the students to use. Overall, we found that the service was not meeting this essential standard and improvements are needed.	
Accommodation and nursing or personal care in the further education sector	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Treloar College is failing to protect people who use the service against the risks associated with the unsafe use and management of medication. Overall, we found that the service was not meeting this essential standard and improvements are needed.	
Accommodation and nursing or personal care in the further education sector	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: We found the college is failing to protect the	

	students because they are not operating safe or effective recruitment procedures when they use staff from an employment agency. Overall, we found that the service was not meeting this essential standard and improvements are needed.	
Accommodation and nursing or personal care in the further education sector	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: We found that although there are enough staff to meet the students' care needs, the provider has found it difficult to recruit enough staff to offer any extra time above the basic care that students may require. Overall, we found that the service was not meeting this essential standard and improvements are needed.	
Accommodation and nursing or personal care in the further education sector	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: We found the students are not being protected against the risk of inappropriate or unsafe care because the system for regularly assessing and monitoring the quality of the service has not identified inadequate practice. The staff responsible have not taken the actions to address any failures until outside agencies have brought these to their attention. We found that the college has not identified risks relating to the health, welfare and safety of the students. Overall, we found that the service was not meeting this essential standard and improvements are needed.	

The provider must send CQC a report that says what action they are going to take to

achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

<table>
<tr><th colspan="4">Enforcement action taken</th></tr>
<tr><td colspan="4">Suspension of registration
This action has been taken in relation to:</td></tr>
<tr><td>Regulated activity</td><td>Regulation or section of the Act</td><td colspan="2">Outcome</td></tr>
<tr><td rowspan="2">Accommodation and nursing or personal care in the further education sector</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td colspan="2">Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td>How the regulation or section is not being met:</td><td>Registered manager:</td><td>To be met by:</td></tr>
</table>

	We found the students were at risk of receiving unsafe or inappropriate care because the planning and delivery of care does not meet their needs. The care plans do not include all of the students' needs and the lack of communication between different care staff around the college means that the students' care needs are not coordinated or kept up to date. Overall, we found that the service was not meeting this essential standard and improvements are needed. We issued a notice of decision to suspend the regulated activity on the 29 July 2011 for one month until the 29 August 2011. This was because we found major concerns that the provider was non compliant and previous compliance actions had not been met. The suspension meant that the provider could not provide the regulated activity accommodation for people who require nursing or personal care for that period of time. The provider accepted the notice of decision and did not make representations or appeal the suspension.		14 August 2011

Enforcement action taken

Suspension of registration

This action has been taken in relation to:

<table>
<tr><th>Regulated activity</th><th>Regulation or section of the Act</th><th colspan="2">Outcome</th></tr>
<tr><td rowspan="3">Accommodation and nursing or personal care in the further education sector</td><td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</td><td colspan="2">Outcome 07: Safeguarding people who use services from abuse</td></tr>
<tr><td>How the regulation or section is not being met:</td><td>Registered manager:</td><td>To be met by:</td></tr>
<tr><td>The students are not protected against the risk of abuse because the college has failed
to report and respond appropriately to allegations or concerns.

Overall, we found that the service was not meeting this essential standard and improvements are needed.

We issued a notice of decision to suspend the regulated activity on the 29 July 2011 for one month until the 29 August 2011. This was because we found major concerns that the provider was non compliant and previous compliance actions had not been met. The suspension meant that the provider could not provide the regulated activity accommodation for people who require nursing or personal care for that period of time.
The provider accepted the notice of decision and did not make representations or appeal the suspension.</td><td></td><td>14 August 2011</td></tr>
</table>

Enforcement action taken

Suspension of registration

This action has been taken in relation to:

Regulated activity	Regulation or section of the Act	Outcome	
Accommodation and nursing or personal care in the further education sector	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	We found that we are not always notified of events or incidents without delay, so the students cannot be confident that important events that affect their welfare are reported to us. If we are not notified we are unable to take any necessary actions. Overall, we found that the service was not meeting this essential standard and improvements are needed. We issued a notice of decision to suspend the regulated activity on the 29 July 2011 for one month until the 29 August 2011. This was because we found major concerns that the provider was non compliant. The suspension meant that the provider could not provide the regulated activity accommodation for people who require nursing or personal care for that period of time. The provider accepted the notice of decision and did not make representations or appeal the suspension.		14 August 2011

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA