Treloar Trust

# Treloar College

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Is the service safe? | Good |

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 26 and 30 September and 7 October 2014 when the service was rated as 'good 'overall. After that inspection in December 2016 we received some information of concern in relation to students receiving their medicines via an enteral feeding tube. As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Treloar College on our website at www.cqc.org.uk. Our findings at this inspection have not changed the current rating of 'good' for the key question of Safe or the rating of 'good' this service overall.

This inspection took place on 8 December 2016 and was unannounced. Treloar College is a residential further education college for up to 115 students with physical and, or learning disabilities aged between 16 and 25. Students stayed in houses and flats on the campus. CQC is responsible for inspecting and regulating the residential accommodation of the college as well as inspecting the health care provision at the health centre. At the time of this inspection 110 students were accommodated at the college.

The service had three registered managers in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Enteral feeding refers to the delivery of a prepared feed via a tube directly into the person's stomach or small intestine. This method supports students who cannot maintain adequate nutrition from an oral intake of food or who cannot eat and drink safely. The enteral device may also be used for the administration of medicines. Some of the students living at Treloar College had enteral feeding devices that were used some of the time or all of the time. For example some students had a combined diet of oral and enteral food. Some students also received their medicines via their enteral device.

Students were supported by an onsite team of healthcare professionals that included; nurses, a nutritional support team, dieticians, occupational therapists, physiotherapist and speech and language therapists (SLT). GP's from a local surgery delivered on site surgeries for students who may choose to register with this practice or remain with their own GP's. We found that the staff and healthcare professionals involved in students' care and treatment worked effectively together to provide safe and person centred support.

Each student had individual and specific guidance available to staff in their care plans and medication administration records. These detailed their needs in relation to enteral feeding and medicine administration. Staff confirmed they checked this guidance on every administration. Students' needs were regularly reviewed and guidance was updated as required.

Staff were knowledgeable about the risks associated with enteral feeding. They had completed training and

competency checks by clinical staff to ensure they could support students safely. Specific enteral medicines administration training was undertaken by staff supporting students with medicines and medicines via an enteral route. The provider aimed to complete competency checks of all staff administering medicines and enteral feeding annually we found some staff competency checks required updating.

The service had a robust system in place to monitor and address errors in enteral feeding and medicines. Staff were encouraged to report any near miss, error or serious incident to encourage improvements in practice and keep students safe. Records showed incidents and errors were addressed and improvements were made following analysis of incidents.

Processes were in place and followed to ensure students received the medicines they were prescribed. Students received their medicines in a timely and person centred way taking into account their preferences and specific needs. Medicines were managed safely by the service and the procedures for the supply, ordering, storage, disposal and administration of medicines were followed by staff. We have made a recommendation about the management of topical medicines. Topical medicines are creams and ointments applied to the skin.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The arrangements in place to support students with their enteral feeding and medicines were safe.

We found that student's needs in relation to enteral feeding were managed safely. Guidance, training and support from healthcare professionals were available to staff to promote safe and effective enteral feeding care.

Procedures were in place and followed by the provider's staff to manage medicines for students safely. Students received the medicines they were prescribed by trained staff who followed guidance and processes to ensure students safety.

The rating of good has not been changed from our last inspection. We will review the key question of Safe in full at our next comprehensive inspection.

# Treloar College

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We undertook this focused inspection of Treloar College on 8 December 2016 in response to information of concern received by the Care Quality Commission in December 2016. We inspected this service against one of the five questions we ask about services: is this service safe? This was because we checked that the arrangements in place to support students with their medicines and with enteral feeding were safe.

The inspection was carried out by one adult social care inspector and a pharmacist specialist. Prior to the inspection we reviewed the information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with the director of clinical services, the head of residential services, a GP from the local surgery who works onsite at the college, the acting nurse manager, a dietician, a member of the nutritional support team and an HR team member. We also spoke with six residential care staff members, a residential manager and a deputy residential manager. We looked at ten students' care plans and the records of six staff in relation to training and competency in managing medicines and enteral feeding. We reviewed other documents relating to the safe management of medicines and enteral feeding such as; error and incident reports and analysis, staff practice checks, staffing allocations and quality assurance audits. We looked at the systems in place for managing medicines and spoke with staff involved in the governance and administration of medicines. We observed medicine administration for two students and one student receiving their medicine via the enteral route. We examined eight electronic medicines administration records (eMARs).

Good

# Is the service safe?

## Our findings

Students' needs in relation to their medicines and enteral feeding regimes were assessed prior to their admission to Treloar College. This enabled the college to ensure arrangements were in place to meet the student's needs on their admission. Students either remained under the care of their own GP or transferred their care to the GP practice based in the college. The college had a team of on-site healthcare professionals to support students healthcare needs. These included; a GP and nurses, a nutritional support team, dieticians, occupational therapists, physiotherapist and speech and language therapists (SLT) some of who were dysphagia experts (chewing and swallowing difficulties).

A college nurse sat in with students during their GP appointments unless the student requested to see the GP alone. This joint working arrangement allowed for effective information sharing to support students' needs and ensure their care plans were up to date. For example we saw that notes from a GP consultation clearly stated the actions taken by the GP and as a result the staff had made amendments to the student's care plan to promote their safety.

Each person's enteral support needs were assessed by a dietician in conjunction with other on-site or external healthcare professionals involved in the students care to draw up their 'feeding regime' plan. Each person's feeding regime described the type and amount of feed, the type of equipment used and the detailed instructions of when and how the feed was to be administered. This guidance was contained in each students care plan, displayed in their room and available in the 'eating and drinking' information kept in communal dining areas in the college. This enabled staff to have ready access to the guidance which they were required to read and check each time they supported the student with enteral feeding. Staff we spoke with confirmed they checked this information as described.

Guidance was included in students' care plans to ensure staff were aware of each student's specific needs to mitigate the risks from inappropriate or unsafe enteral feeding. These included information for example; in relation to cleaning of the equipment and caring for the enteral tube access site taking into account the risk of infection or inflammation. The moving and handling needs of the student and the need to take particular care of their enteral device equipment when moving and positioning the student was also included in care plans.

Medication guidance included information on medicines administered via an enteral route, time critical medicines and the action to take if medicines were declined by the student. How and when medication was to be administered and any specific requirements such as how the person was positioned for their medicine administration. When a student had two feeding tubes inserted into both their stomach and small intestine guidance indicated which tube was used for which purpose. Care plans described which tube was to be used for medicine administration. This information was also included on the students Electronic Medicine Administration Record (eMAR). This was important to prevent the administration of medicines via the wrong route. Records showed that the guidance available to staff was comprehensive.

Staff we spoke with told us about the risks associated with enteral feeding such as; "Soreness or pressure

changes which could mean a blockage, you observe the person whilst having the feed and if they were sick I would clamp it off and check no risk from vomit and call the nurse." Another staff member said "(Guidance) is in-depth and on the care plan and on eMAR. This includes times, water and mix. Eating and drinking profiles and feeding regimes are available and every time we do it we check or we could miss changes. Yes it's safe." Other risks identified by staff included disconnection of the device and poor hand hygiene. We saw that electronic care plans and eMAR's were accessible to staff in each person's room. Hand held computer tablets were also used to access this information when the student was out of their room.

Only appropriately trained staff were able to support students with their medicines and with enteral feeding. We spoke with a dietician who told us that staff initially completed basic feeding training which is based on supporting students who eat orally. After staff had proven competence over time they then attended advanced feeding training to enable them to carry out an enteral feed. This included an observed competency check. Training was delivered by a dietician and an SLT and included the risks associated with enteral feeding. A member of the nutritional support team (NST) said "It comes back to making staff check the profile and getting things right every time which is why we are broadening out our observations into learning walk practice checks." A learning walk practice check is a method of auditing a particular practice by observing and evaluating this in action. The NST were planning to carry out regular meal time learning walks in the near future.

Staff that administered medicines received training and went through a competency assessment before administering medicines unsupervised. A staff member told us "We have theory and practice checks before administering it could be two or five times depending on the individual (staff member) we get checked until competent and signed off by the nurses." Staff administering medicines via an enteral device completed training in enteral medicines administration. Staff, healthcare practitioners and managers we spoke with all confirmed staff would only be able to carry out enteral feeding and medicines once they had completed this training and been assessed as competent. The training records we reviewed evidenced this. We observed one person receiving their medicine via the enteral route. The administration was carried out safely.

A programme of practice checks were carried out to ensure staff remained competent in medicines and enteral feeding. The clinical lead told us the aim was to do these annually. Whilst we saw evidence that some staff had completed these checks, in the staff records we reviewed these annual competency checks had not always been completed. This is important to ensure staff remained suitably competent to support students safely. The clinical lead told us they would instruct clinical staff to carry out the required competency checks.

Records showed that when an error in medicines administration had occurred this was recorded and reviewed by the clinical lead. Action was then taken to address the error and to prevent a reoccurrence. For example; when a member of staff made an administration error their competency was re-assessed or they wrote a critical incident reflective account to identify learning and the actions required to prevent a reoccurrence. Quality assurance processes were in place to monitor incidents and identify any trends or actions required to address shortfalls and make improvements to the care students received. For example, improvements had been made to training in enteral feeding, storage of medicines and the timing of care breaks for students as a result of incident analysis.

Following analysis of a recent incident the provider had taken action to mitigate the risks to students from the potential risk of poor communication and continuity of care between providers which could impact on a student's health and wellbeing. This was because some students leave the college to stay with other health and social care providers permanently or temporarily. The provider had introduced a record to be completed by the service they had attended when the person returned to Treloar. The provider had

identified this as a gap because information received from other providers was not always formally recorded.

Student's needs in relation to their medicines, eating and drinking needs and their enteral feeding regime were regularly reviewed with them by the relevant healthcare professionals. This included scheduled reviews and when student's needs changed. Healthcare support was available at all times at the on-site health centre

The service had processes in place to ensure that people received their medicines as prescribed. All medicines were available, in date and suitable for use. We saw staff administer medicines on time and complete the electronic medicine administration records (eMARs) to show what medicines people had received. Staff stock checked the medicine cupboards once a month. Team Leaders audited eMARs at regular intervals throughout the day to make sure people received their medication on time. The service had policies and procedures in place to support the safe management and administration of medicines.

Students had topical medicines prescribed for administration to the skin (for example creams and ointments). The service did not use body maps or have information in care plans to inform staff when and how to apply the medicines to make sure the medicines were used effectively. Whist we saw that staff recorded when the cream was applied, it is important to have this information to hand for staff to check to ensure the correct administration.

We recommend that the service consider current guidance from a reputable source on the administration of topical medicines such as creams and to take action to update their practice accordingly.

Medicines were stored securely within locked cupboards, refrigerators and medicine safes. Staff recorded the maximum and minimum refrigerator temperatures daily to make sure that the medicines were stored in line the manufacturers' specifications. The service had a robust medicine supply process. We saw evidence of good stock accountability and the cupboards were not over-stocked. Medicine waste was managed in line with legislation.

Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the clinic room. When staff administered a controlled drug, the records showed the signature of the person administering the medicine and a witness signature. Stock checks were carried out twice daily.

The staff administered medicines in a way that respected the individual. Staff asked if the person was ready to receive their medicines and tailored the administration to the needs and preferences of the individual. We saw medicine care plans tailored to the specific preferences and needs of the person. Staff told us they were allocated to each individual that required medicines and enteral feeding. We saw an example of the allocations for one of the house which confirmed this. Staff said they were given enough time to support people safely. A deputy residential manager told us "We constantly reinforce to staff and students not to talk to staff doing meds and to keep a calm environment and not to distract." This was to ensure people were supported safely.

The service encouraged students to manage their medicines independently. A named nurse completed the self-administration risk assessment. The risk assessment was completed annually unless something prompted a re-assessment sooner. For example, one person had temporarily ceased to self-administer their medicines as they had recently had some surgery and were not deemed safe to self-administer their medicines.

There was emergency equipment available and the equipment was checked on a daily basis. While the emergency medicines were kept securely in the clinic room, we were not assured that the medicines were easily accessible overnight when only one member of the clinical team was working. Following our Inspection, the clinical lead has confirmed that the policy and practice regarding access to emergency medicines at night is currently being reviewed and changed to ensure that these medicines are available to students in their accommodation. The changes will be in place by the end of January 2017.