Butterwick Limited

Butterwick House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Due to the focused nature of this inspection, we inspected but did not rate the service.

- The service did not always provide mandatory training in key skills to all staff and did not always make sure everyone completed it. Managers did not always monitor mandatory training and did not always alert staff when they needed to update their training.
- Staff completed but did not always update risk assessments for each patient and did not always remove or minimise risks. Staff knew about specific risk issues regarding the children in their care, however, plans in place to address and respond to risk were not always clear.
- The service did not have robust oversight of patient outcome monitoring. They did not use the findings to make improvements and achieve good outcomes for patients.
- Leaders did not always have the capacity, skills, and abilities to run the service. There remained confusion between senior leaders regarding their roles and accountabilities.
- Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

However:

- We saw improvement in the personalisation of care plans. These were comprehensive and reflective of current patient need.
- The provider had taken action to establish an effective system to maintain oversight of the ratification process for policies and procedures.

Our inspection found significant concerns and found continued breaches of regulation which meant that the provider had not complied with the warning notice we issued following the inspection in May 2021. We have issued a notice of decision to impose conditions on the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for children	**Inspected but not rated**	We did not rate this service but inspected safe and well-led. See the Overall summary above for details.

Summary of findings

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Summary of this inspection

Background to Butterwick House

Butterwick House is operated by Butterwick Limited. The service provides hospice services for children and young people from Stockton, Middlesbrough, and surrounding areas. It is registered as a charitable trust and receives funding from the NHS. The hospice has six inpatient beds for the provision of respite care. At the time of the inspection, Butterwick House were admitting a maximum of two patients per week for respite care. Butterwick House is registered to provide diagnostic and screening procedures and treatment of disease, disorder, or injury. At the time of our inspection there was a registered manager in post.

We previously inspected Butterwick House in May 2021 and raised significant concerns with the provider by issuing a warning notice relating to breaches of Regulation 12 and 17. In addition, we issued the provider with requirement notices and told the provider that it must take prompt action to comply with the regulations. In response, the provider issued an action plan outlining how the service had taken action to address the concerns outlined within the warning notice.

This inspection was an unannounced focused inspection of the safe and well-led domains to gain assurance the provider had acted to address concerns highlighted in the warning notice that had been issued to the provider following the May 2021 inspection.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our team consisted of an inspection manager, inspectors, and a pharmacist specialist.

Our team consisted of an inspection manager, inspectors, and a pharmacist specialist, overseen by Sarah Dronsfield, the Head of Hospital inspection (North East).

We spoke with five staff including the Human Resources Manager, Quality and Compliance Manager, Training and Development Co-Ordinator, Clinical Sister, and the Director of Care. We also reviewed four patient files, five volunteer files, a sample of staff training records and current policies and procedures.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

• The service must ensure that it can evidence promptly on request that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely (**Regulation 12(2)(c).**

Summary of this inspection

• The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks **(Regulation 12 (2)(b).**

• The service must ensure that all staff receive safeguarding training for adults and children, as necessary, to evidence that systems and processes are operated effectively to prevent abuse of service users **(Regulation 12 (2)(c).**

• The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this **(Regulation 17(2)(a).**

• The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity **(Regulation 17 (2)(b).**

• The service must ensure that there is a robust process in place that maintains accurate and up-to-date oversight of the mandatory training of staff working within the service **(Regulation 17 (2)(d).**

Action the service SHOULD take to improve:

• The service should consider giving senior leaders within the service a clear, defined roles and responsibilities that support delivery of the service.

Our inspection found significant concerns and found continued breaches of regulation which meant that the provider had not complied with the warning notice we issued following the inspection in May 2021. We imposed conditions on the providers registration, which include the hospice may each admit a maximum of two people already known the service for respite care without our prior written agreement. Any other admissions would need our prior approval.

The service provider must also:

- improve its disclosure and barring policy
- establish an effective process for overseeing mandatory training and other staff competencies
- give us a written copy of safeguarding training for staff
- produce an effective emergency healthcare planning process to keep patients safe
- produce an effective governance system to assess, monitor and improve the quality and safety of services.

The service provider must also report to us monthly, with information to demonstrate compliance with the conditions.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for children	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Hospice services for children

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Hospice services for children safe?

Inspected but not rated

Due to the focused nature of this inspection, we inspected but did not rate the service.

Mandatory Training

The service did not always provide mandatory training in key skills to all staff and did not always make sure everyone completed it.

Managers did not always monitor mandatory training and did not always alert staff when they needed to update their training. We requested the training files for seven trustees, including their training certificates, to review. The provider produced files for three out of the seven trustees employed. They told us that this was all the information the service held. There was no evidence of mandatory training except for one trustee file which contained print outs from a database but no actual training certificates. The provider told us that trustees had not received any training in relation to safeguarding. This is not in line with the providers policy which stipulates all staff within the organisation must receive safeguarding training or with the intercollegiate guidance that outlines all staff must receive basic safeguarding training.

We found an absence of any risk assessment undertaken by the provider for staff who had not undertaken this training. We saw evidence of escalation to senior leaders regarding this issue, but an absence of any further action taken. We raised this as a concern as that had been identified as part of the previous inspection and the provider was unable to demonstrate how they had taken sufficient action to address this.

However, we reviewed the training matrix for staff working within Butterwick House. We saw that staff had received mandatory training and saw evidence of continuous professional development. Health care assistants had completed theory modules for clinical competencies that were not required for their roles in order to expand their current knowledge and skills. We reviewed the training files and certificates for all staff working within the unit, which corresponded with the training matrix provided. We saw that all registered nurses had received Level 3 safeguarding training. The clinical sisters outlined interim arrangements for the escalation of safeguarding concerns due to absences of named safeguarding leads within the service.

Assessing and Responding to Patient Risk

Staff completed but did not always update risk assessments for each patient and did not always remove or minimise risks.

Staff knew about specific risk issues regarding the children in their care, however, plans in place to address and respond to risk were not always clear. We reviewed four sets of care plans, multi-disciplinary team discussion notes, medicine

records and nursing notes. We found that in one patient record, a protocol for epilepsy management that had a different dose to the emergency healthcare plan in place. The Hydrocortisone dose recorded in the emergency health care conflicted with the dosage listed in other documents within the patients file. In addition, we found within the patient record a conflicting Buclam protocol where an incorrect dose is referred to within the care plan. These discrepancies had not been identified within the provider's medication audit, care plan audit or audit undertaken by external pharmacy input.

We raised these issues with senior leaders on the unit who explained that they had been unable to obtain an updated emergency healthcare plan. We raised this as a concern as that had been identified as part of the previous inspection and the provider was unable to demonstrate how they had taken sufficient action to address this.

Records

Staff kept detailed records of patients' care and treatment. However, records were up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed four sets of care plans including multi-disciplinary team discussion notes, medicine records and nursing notes. Care plans were comprehensive of patient needs, personalised and up to date. Correct patient names and genders were used throughout all records. We saw evidence of documentation audits being undertaken. In all records reviewed, the nurse pre-admission check audit form was present and had been completed. We saw evidence of actions being taken in light of audit findings.

We saw in all records reviewed, the service had taken action to archive information that was no longer current or accurate. This information had been removed from current care plans and placed into an archived folder in order to ensure care plans were reflective of the patients' current need.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always investigate incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Managers did not always investigate incidents thoroughly. We requested a copy of the providers incident log and a reviewed one completed incident investigation pack. We found gaps within the incident investigation documentation, as not all areas had been completed. We found no completed or associated action plan within the incident investigation pack. We found whilst there were areas for learning identified within part 1e, there had been no member of staff identified or allocated to ensure these were actioned and implemented accordingly.

Staff did not always received feedback from investigation of incidents. We found no evidence within the incident investigation pack of learning being shared or disseminated with the immediate team or across the service more broadly. We reviewed the corresponding entry within the provider's incident log and found that there had been no completed entry detailing learning from the incident. This is not in line with the provider's policy for the management and investigation of incidents.

We raised this as a concern as that had been identified as part of the previous inspection and the provider was unable to demonstrate how they had taken sufficient action to address this.

Inspected but not rated

Hospice services for children

Are Hospice services for children well-led?

Inspected but not rated

Due to the focused nature of this inspection, we inspected but did not rate the service.

Leadership

Leaders did not always have the capacity, skills, and abilities to run the service. There remained confusion between senior leaders regarding their roles and accountabilities.

During the inspection, we observed that several senior leaders were absent from the service. We observed several ad-hoc interim arrangements in place, but an absence of any formalised arrangements. The absence of key leaders within the service had a demonstratable impact on the providers ability to work at pace to address concerns raised as part of the May 2021 inspection. We were not assured that the provider would be able to act in a timely manner to address concerns raised by CQC with the level of sustained absence across the senior leadership team.

We raised concerns with the provider regarding the capacity of the senior leadership team to act on the highlighted issues, as this was an area of concern identified at the previous inspection.

Governance

Whilst limited progress had been made, we were not assured that the service had effective governance processes and robust oversight of patient outcome monitoring. They did not use the findings to make improvements and achieve good outcomes for patients.

We reviewed four sets of care plans, multi-disciplinary team discussion notes, medicine records and nursing notes. We found limited evidence of patient outcomes being measured. In two of the records reviewed, we found a measuring outcome of patient care document present within the file. In the first record reviewed, the form was present but had not been completed. In the second record, this had been partially completed to a poor standard as columns related to implementation and evaluation had not been completed. In all records reviewed, we found no evidence within nursing notes or multi-disciplinary team discussion notes of any discussion regarding patient outcomes. This was also absent in any admission or discharge discussion notes. We were not assured as to how the service were maintaining oversight of how the care and treatment provided impacted patient's outcomes.

We reviewed the audit activity spreadsheet for Butterwick House. We saw that whilst admission and discharge documentation audits had been completed, a care plan audit had not been undertaken within the date range provided. We raised this as a concern as that had been identified as part of the previous inspection and the provider was unable to demonstrate how they had taken sufficient action to address this.

However, we saw evidence of areas for improvement being identified through the audit of admission and discharge documentation and saw the provider had process for allocating actions to address areas for improvement identified through the audit process. The audit activity spreadsheet contained details of who maintained responsibility for implementing actions and contained dates for completion.

We reviewed a copy of the providers current policy log. Senior leaders outlined the current process for maintaining oversight of the ratification process for policies. The policy log had been colour coded to signify the current status of policies, with each policy being assigned to a senior leader for responsibility. The policy log detailed dates of ratification and dates for review. Once ratified and reviewed, the most current version of policies and procedures are now stored within a folder on a public drive to be accessed electronically by all staff.

Management of Risk, Issues and Performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

We reviewed the Human Resources (HR) files for five volunteers and two maintenance staff. We found that in all files, there was no evidence of a Disclosure Barring System (DBS) check. We raised this with the provider who outlined that some, but not all DBS checks were held electronically. The provider clarified that there was potential for staff to have unsupervised access with vulnerable adults and children.

We reviewed the providers DBS policy and the DBS policy and the associated disclosure and barring roles checklist. DBS checks are a tool to ensure staff and patients are safeguarded from the risk of potential harm or abuse.

We spoke with senior team leaders who provided conflicting statements, regarding the processes in place for DBS checks. Senior leaders also outlined that where a DBS had been undertaken, the outcome of this was not recorded. This is not in line with current national guidance. We were not assured that the provider had sufficient processes in place to mitigate patients from potential harm or abuse. There was an inconsistent approach to staff recruitment as we also reviewed clinical staff files and found that they contained the required information.

We reviewed a copy of the most recent risk register. We found that this had been updated to reflect current risks and had captured concerns raised as part of the May 2021 inspection.

We reviewed the providers current policy for Infection, Prevention and Control. We saw that this had been amended to make reference to COVID-19 and directed staff to the providers protocols for COVID-19. We observed that the amendments to this policy had been recorded and details on the providers policy log.

We reviewed a copy of the providers plan for recommencing end of life services. The plan comprised of a list of actions for the service but was not measurable and lacked an underpinning strategy and aim. The plan lacked sufficient detail as to how the provider would take the required actions to recommence end of life care. We raised this with the provider as this was an area of concern that had been identified as part of the May 2021 inspection. Senior leaders acknowledged the shortcomings of this plan and outlined further work would need to be undertaken to produce a more detailed strategy and plan to address this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that it can evidence promptly on request that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely (**Regulation 12(2)(c).** • The service must ensure that staff fully and properly assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks **(Regulation 12 (2)(b).** • The service must ensure that all staff receive safeguarding training for adults and children, as necessary, to evidence that systems and processes are operated effectively to prevent abuse of service users **(Regulation 12 (2)(c).**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activity and include the experiences of service users within this (Regulation 17(2)(a). • The service must assess, monitor, and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity (Regulation 17 (2)(b). • The service must ensure that there is a robust process in place that maintains accurate and up-to-date oversight of the mandatory training of staff working within the service (Regulation 17 (2)(d).