Butterwick House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Butterwick House is operated by Butterwick Limited. This service location provides hospice care for children from Stockton, Middlesbrough and surrounding areas. The hospice cared for 42 children and young people in the last year.

Butterwick House is registered as a charitable trust and also receives funding from the NHS.

The hospice has six inpatient beds, two of which are reserved for the provision of respite care.

We carried out a focused inspection on 12 February 2020 to follow up on improvements made by the hospice to address concerns raised at our comprehensive inspection 5 November to the 11 December 2019. The service had recently re-opened following a voluntary suspension of the service for a period of six weeks. At the time of the inspection the hospice was open Monday to Saturday and was only admitting children and young people already known to the service for short-break respite care. It was not taking new referrals or end of life children or young people at this time.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Services we rate

As this was a focussed inspection, we did not inspect all five key domains. This means the service was not rated on this occasion and ratings from the previous inspection still apply. We inspected areas of; Safe, Effective and Well-led.

At our last inspection we found several issues that the service provider needed to improve;

- Disclosure and barring checks for staff and volunteers were not updated regularly and the service did not hold a comprehensive record of when to update these. This situation had been improved, all staff had received the appropriate checks and a system had been put in place to ensure managers had clear oversight and were alerted when checks became due.
- Previously, staff did not have the right levels of safeguarding training to meet intercollegiate guidance (2019). All staff had since been trained to an appropriate level, and policies had been updated to reflect training needs, in line with guidance.
- Incidents were not always reported and investigated. Learning from incidents was not adequately shared. At this inspection we found the incident policy was being reviewed and work was being undertaken to improve reporting. Nominated staff were to be

Summary of findings

trained to undertake investigations/ root cause analysis. However, it was still not clear how learning was shared with staff and policies did not make clear staff and the organisation's responsibilities with regard to being open with children, young people and their families and duty of candour. Work to improve the incident policies and processes was ongoing but needed further work.

- Medical cover was now available at evenings and weekends to ensure that children and young people could be reviewed quickly if needed.
- Staff were not previously supported with mandatory training and managers had no oversight of the training needs required for the role. Staff did not always have the right competencies to care for their patients. A training policy had been developed and all staff had been brought up to date with their mandatory training requirements and had undergone a number of clinical competency assessments.
- Patient records, risk assessments and escalation plans had been brought up to date for the children and young people staying in the hospice at the time of our inspection. A process had been implemented to ensure this happened for every patient at their next attendance / admission. The format of assessments, care plans and other patient documentation had been reviewed and improved. We found risk assessments and care plans were of a good standard.
- The sunflower room (for deceased patients) and the policy regarding its use was now fit for purpose. The policy covered ventilation, air cooling/ conditioning and the use of a cooling cot and blankets. The room was now safe for use and could be re-opened.
- Managers were in the process of consulting with their professional networks including the network for children's hospices in the North East to look at developing indicators or outcomes that could be benchmarked with other similar providers.
- Governance arrangements including new systems and processes were being strengthened and or implemented to enable proper oversight of performance and risk. This work was ongoing. Governance systems needed to include staff who were employed by other organisations but provided services at the hospice.
- All policies had been risk assessed and prioritised using a red, amber, green rating system. Work to fully review and update all hospice policies was progressing but was an ongoing piece of work.
- The service was responsive to the concerns we had brought to its attention and the leadership team were eager to continue their initiatives to improve services.

Although the hospice had made significant improvements, the service needed to continue to limit its admissions to respite care and children already known to the service. We asked the hospice to develop an action plan with clear objectives and milestones to ensure a controlled and safe reopening to new admissions/ referrals, end of life admissions and emergency admissions.

Following this inspection, we told the provider that it must continue with its actions to comply with the regulations breached and requirement notices issued at the last inspection. Details to be found in the inspection report published 26 March 2020.

Ann Ford

Deputy Chief Inspector of Hospitals, North

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Background to Butterwick House

Butterwick House is operated by Butterwick Limited who provide adult hospice services at the same site and a range of wider services to the local community. The hospice was purpose built in 1997 and sits within the grounds of a local NHS hospital. It provides specialist end of life care, day care, respite care and family support for children, young people and their families with a range of life-limiting conditions living in Stockton, Middlesbrough and the surrounding areas.

The hospice provides inpatient accommodation for up to six children and young people. At the time of our inspection, 36 children were accessing the service, all of whom did so on a respite care basis.

The hospice also offers bereavement counselling services. These services are outside the scope of our regulation and therefore we did not inspect these services.

It receives funding from two local Clinical Commissioning Groups (CCGs) and through charitable donations.

The hospice has had a registered manager in post who was registered with the CQC since 2014.

At the previous comprehensive inspection in November - December 2019, the provider was asked to take urgent action to address our concerns with some aspects of the service. The provider voluntarily suspended its service for a period of six weeks to enable improvements to be made. In addition, we told the provider that it must take some actions to comply with the regulations and we issued the provider with four requirement notices that affected Butterwick House. At this inspection, we inspected the parts of the Safe, Effective and Well-led key questions to ensure improvements had been made and the service was safe to re-open.

As this was a focussed inspection, we did not rate the service on this occasion. This means the ratings from the previous inspection published 26 March 2020 still apply.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and an inspection manager. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Butterwick House

The hospice has inpatient and day-care facilities and is registered to provide the following regulated activities;

• Transport services, triage and medical advice provided remotely

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

Up to six children and young people could be accommodated in the inpatient unit in separate, ensuite rooms. The hospice also housed a sensory room, main day room and day room for teenagers and young adults, and hydrotherapy pool. The hospice also offered day therapies and family support services which included adult and child bereavement support and counselling.

The hospice had a board of trustees and two subcommittees that fed into this. Senior leadership was provided by the chief executive, and the director of patient care and service development.

During our inspection we spoke to staff including; managers, registered nurses and doctors. We observed

Summary of this inspection

care and treatment and looked at three sets of patient notes, care plans and medicines administration records. We reviewed updated policies and processes and looked at staff recruitment and training files.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the service provider had made the following improvements;

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff were now up to date with their mandatory training and managers had implemented a process to enable oversight of training compliance and updating of staff skills needed to fulfil their roles safely and competently.
- Staff had all received the appropriate level of training on how to recognise and report abuse. Systems were in place to protect children and young people from abuse and to enable staff to raise concerns.
- Staff completed and updated risk assessments for each patient to remove or minimise risks. Risk assessments considered children and young people's individual needs and included actions to be taken if a child became acutely unwell or their condition deteriorated unexpectedly.
- The service controlled infection risk well. Staff used equipment and control measures to protect children and young people, themselves and others from infection. New guidance had been developed for 'management of an outbreak of infection' and 'Management of a patient with a suspected or known infection'.

We found the following areas the provider needed to improve;

- The hospice needed to source evacuation equipment and review staff training needs before the hydrotherapy pool could be re-opened.
- The service did not always manage patient safety incidents well. Incident policy and processes were not adequately described, and staff responsibilities were not clear.

Are services effective?

We found the service provider had made the following improvements;

- The service made sure staff were competent for their roles.

Are services caring?

We did not inspect caring as part of this inspection

Are services responsive?

We did not inspect responsive as part of this inspection

Summary of this inspection

Are services well-led?

We found the service provider had made the following improvements;

- Leaders were responsive to the concerns we had brought to their attention and the leadership team were eager to continue their initiatives to improve services.
- Leaders and teams had started to use systems to manage risks, issues and performance more effectively. They had started to identify risks and to look at how these were escalated.

We found the following areas the provider needed to improve;

- Governance processes, throughout the service were not yet complete and effective.
- Risks were still recorded in several places therefore oversight and prioritising was difficult. There was no clear escalation pathway from local risk assessments to the corporate risk register.

Hospice services for children

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are hospice services for children safe?

We did not rate Safe at this inspection.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff were now up to date with their mandatory training and managers had implemented a process to enable oversight of training compliance and updating of staff skills needed to fulfil their roles safely and competently.

The provider had developed a training policy to define required mandatory training for each to job role. This included key clinical competencies required for each job role and when refreshers / training should be completed. The managers had developed a training matrix which showed substantive staff had now completed the mandatory training required. The matrix also showed that a large number of clinical competency assessments had also been completed for key topics such as medicines management, management of epilepsy, Sepsis, chest physio and mouthcare.

There were however still some assessments and training to be completed, this was mainly for bank staff and new staff. Managers told us that bank staff would not be able to work until their key competencies and training were up to date.

Three staff had been identified to become the assessors for the other staff, one sister and two other registered nurses. The local trust had offered some support with train the trainer education for some topics and had given the hospice access to the skills room for simulation exercises. The training matrix and staff files we looked at showed that all staff had undergone clinical competency assessments appropriate to their role.

We found the induction booklet and other competency booklets had been reviewed or developed and it was evident from the matrix and staff files we looked at that competency had been assessed. New staff were allocated a mentor and were supernumerary members of staff for a four-week period.

Volunteer files we looked showed that these members of staff had received an induction and a volunteer induction workbook had been developed.

The hospice doctor told us that medical staff mandatory training was provided by their main employer and that compliance with mandatory training was checked through the appraisal process. They recognised that there had not been a formal process in place to provide this assurance and had developed new documentation to ensure this was checked and consistently recorded. The doctor was due to present the new documentation and process later that day to the other medical staff for comment and approval.

Safeguarding

Staff had all received the appropriate level of training on how to recognise and report abuse. Systems were in place to protect children and young people from abuse and to enable staff to raise concerns.

Disclosure and barring checks for staff and volunteers had been improved, all staff had received the appropriate checks and a system had been put in place to ensure managers had clear oversight and were alerted when checks became due.

The service had sought help from the local NHS trust to develop and implement a system for overseeing the renewal of disclosure and barring service (DBS) checks every three years. All staff working in the hospice had this check done within the last three years. The hospice had introduced a process whereby they would alert staff at three month and one month intervals that their renewal check was almost due and would suspend a member of staff from duty if their DBS passed the three year date

The provider had reviewed the safeguarding policies and had ensured training was now in line with intercollegiate guidelines.

All staff (including volunteers) had now received the updated training at the appropriate level. All registered nurses had been trained to level three, the volunteer had been trained to level two and the provider had made the decision to identify three named safeguarding individuals across the organisation who would be trained to level four. There was a named safeguarding lead in place.

The same process had been put in place to ensure nursing and allied health professional staff maintained current professional registration. However, these processes needed to include medical staff too. The human resource manager said they would add medical staff to the system straight away.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children and young people, themselves and others from infection. They kept equipment and the premises visibly clean.

The service had developed guidance on 'Management of an outbreak of infection', 'Management of a patient with a suspected or known infection'. and had addressed the concerns we had regarding the sunflower room and care of the deceased.

The sunflower room and the policy regarding its use was now fit for purpose. The policy covered ventilation, air cooling/ conditioning and the use of a cooling cot and blankets. The room was now safe for use and could be re-opened.

Although there was an action plan following the last infection control audit there was no evidence these actions/risks had been escalated to the hospice risk register. This meant there was no oversight of these risks. There was no record of any mitigations or escalation and progress was not evident, as some risks had been highlighted by the external auditor repeatedly over a number of years.

Environment and equipment

The hospice needed to source evacuation equipment and review staff training needs before the hydrotherapy pool could be re-opened. The hospice premises had been risk assessed regarding potential ligature risks.

Where blind draw cords were in use, these had been secured to reduce the risk of any potential risk of choking or ligature. Risk assessments had been completed for each of the rooms and the main mitigation was that children and young people and visitors were never left alone in these rooms. Staff told us that there was always at least one of them present in the room with children and families and that they had acted to remove other potential hazards from the patient rooms.

The hydrotherapy was not being used during the inspection. Staff told us guidance was being reviewed about their training needs and that they were searching for suitable evacuation equipment that would fit the dimensions of the room. The pool was not going to be re-opened until these actions had been completed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient to remove or minimise risks. Risk assessments considered children and young people's individual needs and included actions to be taken if a child became acutely unwell or their condition deteriorated unexpectedly.

We reviewed three sets of children's notes. Records, risk assessments and escalation plans had been brought up to date for the children and young people staying in the hospice at the time of our inspection. A process had been implemented to ensure this happened for every patient at their next attendance / admission. The format of assessments, care plans and other patient documentation had been reviewed and improved. We found risk assessments and care plans were of a good standard.

Hospice services for children

Resuscitation and assessment, treatment and care policies were also being reviewed as an organisation wide piece of work to risk assess, rate and update out of date policies. The assessment, treatment and care policy had been reviewed and it had been agreed that all risk assessments and care plans would be done at first admission and a documented review would be completed at every admission (with changes made where necessary).The new policy stated that a medical review would be undertaken by the hospice doctor every three months.

Personal emergency evacuation plans had been completed and were easily accessible in a grab and go folder should an emergency arise.

All children had their own named lead paediatrician who was from an acute NHS organisation and there was evidence of communications and updates to the hospice from the lead consultant. Admissions for respite care were pre-booked which enabled the hospice to gain an update from the child's lead consultant and to assess the child's acuity. This information enabled the hospice to judge appropriate staffing levels and identify the skills required to manage the child's admission and ongoing care.

The hospice had acted to ensure children were only admitted when the hospice doctor associate specialist was on duty so medical assessments were carried out on the day of admission.

We found that staff could access medical support and advice 24 hours every day. This was provided by; the hospice doctors Monday to Friday (8am to 5 pm); ringing the paediatric assessment unit at the adjacent hospital (8am to 10pm) or from the paediatric registrar on call at the hospital. Although the arrangement with the hospital was informal there was work ongoing to formalise this in a 'service level agreement'.

Staff told us that if necessary, after discussion with the hospital paediatric team and if the child was able, they could transfer them to the paediatric assessment unit or the emergency department for review. In case of emergency or if staff were unable to take the child to the hospital for a paediatric assessment, they could call the 999 emergency number and arrange an ambulance transfer.

Although the hospice had made many improvements, they needed to continue to limit its admissions to respite care and children already known to the service. The hospice needed to develop an action plan with clear objectives and milestones to ensure a controlled and safe reopening to new admissions/ referrals, end of life admissions and emergency admissions.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment.

The hospice had recruited to most of its vacancies and the last two posts would be filled by May 2020. Managers hoped they would be able to start to admit emergency and end of life patients when they were fully staffed.

We reviewed the staff files of two new starters and saw they had completed an induction and had been competency assessed.

The hospice used the Leeds dependency tool to assess staffing needs and was undertaking work with the local authority to improve how this fitted with their continuing health care needs assessment.

Medical staffing

The hospice employed an associate specialist doctor for the children's unit three days a week, the two doctors who covered the adult services also supported the children's hospice when needed. Five GPs with a special interest covered 5 p.m. to 8 p.m. weekdays and 5 p.m. Friday to 8 a.m. Monday. As part of the weekend cover role the GPs carried out weekend ward rounds.

We acknowledged that arrangements for medical cover were in place but as this was quite complex over 24 hours / seven-days a week, there needed to be a clearer information process in place for staff to ensure they knew the correct cover arrangements.

Incidents

The service did not always manage patient safety incidents well. Incident policy and processes were not adequately described, and staff responsibilities were not clear.

Hospice services for children

We found that work had been undertaken to improve incident reporting and a review of incident reporting, investigation and management was ongoing. There was a plan for specific individuals to undergo training in investigation and root cause analysis. However, it was still not clear how learning was shared with staff. In addition, policies did not make clear the staff and the organisation's responsibilities in relation to being open with children, young people and their families and duty of candour. Neither did they describe clearly when formal duty of candour would be triggered, at what level of harm or the process that would be followed.

Duty of Candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Are hospice services for children effective?
(for example, treatment is effective)

Competent staff

The service made sure staff were competent for their roles.

Since our previous inspection the hospice had undertaken a lot of work to ensure all staff were up to date with training and were competent to undertake their roles.

The hospice had developed a clinical supervision policy and aimed to link reflection on complaints and incidents into supervision sessions. Nursing staff were able to attend clinical supervision sessions four times a year. These would be documented in form of a clinical supervision contract; a record of the discussion would be made, and a record kept of attendees.

Managers had identified four staff who would be able to take on the role as clinical supervisors and the local trust had provided some training for these staff to be able to fulfil this role.

We saw that the hospice had developed a new annual appraisal process and document for the hospice doctors and contracted GPs, but this had not been implemented yet. The documentation covered the doctors' responsibilities, continuing professional development, strengths and areas for development, confirmation of last DBS and completion of mandatory training. The new process and documentation were on the agenda to be discussed at the doctors meeting on 12 February 2020 and would be implemented after that.

Doctors meetings were held bi-monthly and acted as a forum to discuss, items such as incidents, job plans, appraisals, CPD etc. The hospice doctor was a member of the North east children's palliative care network and we saw evidence of attendance at the last meeting in November 2019.

We reviewed five nursing staff files which contained evidence of professional registration, DBS and assessment of competence. Registered nurses and health care support workers had all completed additional role specific training. Examples of competency-based training included medicines management, catheter care and care of percutaneous endoscopic gastrostomy (PEG) feeding tubes and feeds.

We reviewed two medical staff files which contained evidence of professional registration, DBS and revalidation. The hospice doctor told us that the required skills of the GPs was tested through the recruitment process and reinforced by their job plan and appraisal, where development needs and performance could be identified.

We viewed the new logs for oversight of training and professional checks and found that all nurses had training dates, dates of DBS checks and professional registration recorded where relevant. We noted that medical staff had not been included in the logged information although general Medical Council (GMC) numbers were recorded in the two medical personnel files we looked at. When we checked we found registration for these doctors was current. When we spoke to managers, they said this was an oversight and they would add the medical staff details to the logs to ensure the same level of oversight.

Patient Outcomes

Hospice managers had arranged a meeting with the other children's hospices in the North East and attended paediatric palliative care meetings to help develop a collaborative approach to developing indicators for clinical audit and benchmarking of patient outcomes.

Hospice services for children

Are hospice services for children caring?

We did not inspect Caring as part of this inspection.

Are hospice services for children responsive to people's needs? (for example, to feedback?)

We did not inspect Responsive as part of this inspection.

Are hospice services for children well-led?

Leadership

Leaders were responsive to the concerns we had brought to their attention and the leadership team were eager to continue their initiatives to improve services.

A new clinical leader for the children's hospice had been in post since 6 January 2020. They had a good understanding of the issues the service faced and had plans to address these. The leadership team had developed an improvement action plan since our last inspection and could demonstrate that they had made progress to tackle the concerns we had raised. Leaders were aware and acknowledged that there was a lot of work still to do.

Staff told us they were aware of the improvements needed and had been involved in making some of the improvements needed.

Governance, managing risks, issues and performance

Governance processes throughout the service were not yet complete or fully effective. Leaders and teams had started to use systems to manage risks, issues and performance more effectively. They had started to identify risks and to look at how these were escalated. However, risks were recorded in several places and there was no clear link between local risks, which may have been identified through an audit, and the corporate risk register. This meant leaders did not have full oversight of all the risks in the organisation.

Governance arrangements including new systems and processes were being strengthened and or implemented to enable proper oversight of performance and risk. This work was ongoing. For example, systems were now in place to ensure effective oversight of staff training, professional registration and DBS checks. This now included volunteers and trustees but medical staff and allied health professionals needed adding.

We saw that staff had carried out risk assessments for the environmental risks we had raised at our last inspection. We found that all policies had been risk assessed and prioritised using a red, amber, green rating system. Work to fully review and update all hospice policies was progressing but was an ongoing piece of work. The policy group was in place to oversee this work and a process had been put in place for ratification by the board.

However, risk assessments at local level had not yet been collated and were incomplete. Some risks were identified on action plans from audits such as infection control, some were on the hospice's CQC action plan and some were in local risk assessment folders. As yet there was no clear pathway for escalation of risk to ensure senior managers and trustees were aware of them or that they could be prioritised for action.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The hospice must continue its actions to address the breaches of regulations 11 Consent, 12 Safe ace and treatment, 13 Safeguarding service users from abuse and improper treatment, 17 Good governance, 18 Safe staffing and 20 Duty of candour as identified in the report published 26 March 2020. Although some improvements have been made, not all breaches have been fully addressed. Improvements that have been made or started need to be completed, embedded and sustained.

Action the provider SHOULD take to improve

The hospice should continue to act to address the other areas of improvement identified in the report published 26 March 2020, even though these had not been a breach of regulation.

In addition,

- The hospice should consider how it could access peer or expert review of its policies to streamline them and ensure they contain all the content necessary to reflect current guidance, best practice and legislation. (Regulation 17; Good governance)
- The hospice should consider collating local risks all in one place so there can be clear oversight which would facilitate escalation to the corporate risk register and management team. (Regulation 17; Good governance)
- The hospice should consider how it gains and records assurance that all staff not directly employed by the service are up to date with DBS, professional registration/ revalidation, mandatory training and appraisals. (Regulation 17; Good governance)