Butterwick Limited

Butterwick House

Inspection report

Middlefield Road
Hardwick
Stockton On Tees
TS19 8XN
Tel: 01642607748
www.butterwick.org.uk

Date of inspection visit: 14 and 15 October 2020
Date of publication: 11/12/2020

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 effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We inspected Butterwick House because we had concerns about the quality of services. The provider reported four medicines incidents since reopening to children in July 2020. We were provided with detail of the four incidents by the provider, and on review of this information our concerns were sufficient to merit a short notice, announced inspection. We carried out a focussed inspection at Butterwick House on 14 and 15 October 2020 to review the processes, procedures and practices around medicines management, incidents and governance. We looked at parts of the safe and well-led domains.

We did not rate services because this was a focussed, short notice inspection in response to specific areas of concern. We inspected medicines practices and processes at Butterwick House, the medicines management training provided to staff, and how their knowledge was checked, and how they reported and investigated incidents. We also looked at the wider oversight and management of incident management and risk across the organisation.

We found;

- The service did not have staff with the right training to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep detailed records of patients' care and treatment.
- The service did not use systems and processes to safely prescribe, administer and record medicines.
- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers did not investigate incidents thoroughly and we found no evidence that they shared lessons learned.
- Leaders did not operate effective governance processes, throughout the service and with partner organisations and did not use systems to manage performance effectively.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

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	• Staff did not have the right qualifications and training in key skills, to keep patients safe from avoidable harm. Staff did not assess risks to patients, or act on them to maintain good care records. They did not manage medicines or safety incidents well and did not learn lessons from them. Staff did not collect safety information and used it to improve the service. • Leaders did not operate effective governance processes, throughout the service and with partner organisations. Systems were not developed to support staff to develop their skills. Risk was not managed adequately and there was a lack of risk oversight and management by leaders of the organisation.

Summary of findings

Contents

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 also receives funding from the NHS.

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

Butterwick House is registered to provide diagnostic and screening procedures, transport services, triage and medical advice provided remotely, and treatment of disease, disorder or injury.

At the time of our inspection there was an application in progress for a registered manager.

We inspected Butterwick House in November 2019 and rated the safe, effective, responsive and well led domains as inadequate. We did not rate the caring domain as the provider was undertaking limited activity and there was insufficient information to make a judgement about this domain. We found, amongst other issues, that staff did not have the correct competencies to care for their patients, there was insufficient attention to safeguarding, incidents were not always reported and investigated, and governance arrangements were not fully formed. We placed the service into special measures as a result of this inspection. The provider produced an action plan in response to our concerns.

We returned in February 2020 to follow up on improvements made by the hospice to address these concerns. We found that there had been some improvement, but further work was still needed. We did not rerate the service at this inspection, and the provider remained in special measures. Following this inspection, we told the provider it must continue with its actions to comply with the regulations breached and requirement notices issued during the November 2019 inspection.

Previous reports relating to this provider can be found here; https://www.cqc.org.uk/provider/1-101634397

How we carried out this inspection

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 provider MUST take is necessary to comply with its legal obligations. Action a provider 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.

We told the provider that it must take action to bring services into line with legal requirements.

- The hospice must ensure that the assessment of risk of children is systematic, underpinned by policy, regular, and that care plans reflect this to ensure the safe care of children. Regulation 12 (2) (a)

Summary of this inspection

- The hospice must ensure that incidents, including medication incidents, are properly reported and investigated, and that actions/learning is embedded to prevent similar incidents occurring in the future. Regulation 12 (2) (b)
- The hospice must ensure that effective and robust systems are in place to assess, monitor and improve the quality and safety of the services provided including:

- ensuring that effective policies and procedures are place to support staff to protect children from exposure to the risk of harm.

- ensuring that leaders and the board have appropriate and timely information to review and improve the effectiveness of the service. Regulation 17 (2) (a)

- The hospice must review the current risk register so that there is a robust system for the identification and assessment of risk and risks are regularly revisited and monitored. Regulation 17 (2) (b)
- The hospice must provide appropriate ongoing supervision and training, including checking learning and understanding, to ensure staff can carry out the duties they are employed to perform. Regulation 18 (2) (a)

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	Inspected but not rated	Inspected but not rated	Inspected but not rated	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

- The service did not have staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Nursing staff had not all received up to date training on how to manage medicines safely. There was no evidence that their understanding and how they used this learning to provide safe care for children had been checked. Staff involved in medication errors had not had their skills and understanding rechecked after these incidents. Training provided to staff did not echo, and sometimes contradicted policies in use by the provider.
- Concerns regarding staff competencies were reported at the previous inspection in November and December 2019 and a requirement notice was served stating 'Staff working with children and young people did not have the correct competencies.'
- During our site visit on 14 October 2020, there was limited evidence that nursing staff on shift had the required medication competencies to safely care for the children. The staff on duty had been involved in the medication errors.

- We reviewed their training records and found that none of the staff records had an appropriate competency sign-off for a new "Medicine workbook and competency framework" dated August 2020. This was confirmed by senior nursing staff.

- A previous competency workbook had been completed for one member of nursing staff. However, this was signed off by a nurse who had not had their own competency assessed.

- We reviewed the training records of three nurses who administered medication as part of their role. We saw in one file a certificate had been issued for medicines management, but they did not attend the course according to the signing in sheet. There was no evidence of completion of the 'new' August 2020 competency framework. In the second file there was evidence of completion of the 'old' competency framework and observation of their practice. However, they had not completed the new competency framework.

- The third file showed that 'old' competency framework had been signed off but no evidence that competencies had been checked and tick boxes not completed. The 'new' August 2020 competency framework was partially complete.

- Staff did not keep detailed records of patients' care and treatment. Records were unclear, and not kept up to date. Records of children's allergies and any assistance they might need to breathe, eat or move around were not always up to date. Staff did not review patients records regularly so we could not be assured that children and young people would receive safe care and treatment that met their current needs.

- On inspection, we reviewed records for four children and young people who received care at the service and found evidence of poor record keeping and administration of medication, that had not been identified by the provider.

- We reviewed the night care plan for the first patient which showed that prescribed doses of medication had not been given as directed. The correct dose was not captured within the detail of the patient's care plan stating that a dose of 'x' could be administered at night. However, on review of the MAR (medicine administration record) chart directions, this stated that a further dose could be administered if needed. It was recorded that the patient had received a second dose on the previous three evenings consecutively. Guidance for this additional dose was not included in their care plan.

- In the section of the care plan relating to pain relief, PRN (pro re nata, which means to be given as the medicine is needed, not routinely) medication was recorded only as paracetamol for the first patient. However, it was recorded as PRN ibuprofen and paracetamol on the MAR chart. There was no guidance as to how this pain relief would be administered. This contradicting information could result in the under or overdosing of the patient and placing them at risk of harm.

- We reviewed key assessment documents relating to fundamental care and treatment. We saw staff had not completed needs assessment documentation which included pressure area care, pain management and assessment, epilepsy and skin condition assessments. In one patient file we saw staff had not signed or dated the emergency assessment form for resuscitation. This lack of information could result in a delay to seek urgent emergency care and treatment, placing them at risk of harm. Inspectors raised this with the provider immediately on site.

- We saw that staff had also not completed equipment checklists, as requested by the 'Referral, Assessment and Admission Criteria procedure', when a patient brings their own equipment into the hospice. This may lead to the wrong equipment being used and placed the child at risk of harm. This was raised as a concern during the previous inspection in 2019.

- The service did not use systems and processes to safely prescribe, administer and record medicines. Four medication errors had taken place in August and September 2020 prior to our inspection. We found documentation of medicines was not consistent, with unclear guidance for staff, and policies were not being followed. Medication care plans were not person centred or signed, and some contradicted other documents stored elsewhere in children's care plans. We found evidence that patients had not always received all of the medicine their parents or guardians had requested they receive.

- We saw the 'Transcribing Medicines procedure' stated that 'as part of the admission process the nurse and second checker will complete the medicines administration record in the presence of the parent'. We found that this was not completed for any of the four records we reviewed.

- Inspectors on site were supplied with five different documents, all described as current, covering the transcription of medicines. Two were teaching materials for completion by all staff, the other three were policy or protocol documents. None of the five considered the most recent Royal Pharmaceutical Society guidance.

- Two of the five documents stated the nurse in charge should transcribe. The other three stated a dedicated admissions nurse should transcribe. Four of the five stated (or implied) that one nurse should transcribe alone. The fifth stated that the first nurse should be overseen by a second nurse. In addition, one document was 11 years out of date.

- None of the documents (nor the medicines management policy) covered what to do if there was an error.

- During inspection, we reviewed records for four children and young people who received care at the service and found evidence of poor record keeping, including administration of medication that had not been identified by the provider.

- Patient A was prescribed medication at night, however the correct dose was not reflected within the care plan. This patient was also prescribed two types of, PRN (pro re nata, which means to be given as the medicine is needed, not routinely) medication. However, one type was shown on the medication records.

- We reviewed this against the management of medicines and medical gases policy and found that this policy developed by the provider did not include reference to PRN medication.

- We found no specific guidance as to how PRN medication should be recorded.

- Patient B also required PRN medication up to four times daily or ibuprofen up to three times daily. This was not clear in the medication chart and care plan documentation. There was some person-centred information for the pain relief in the care plan but no guidance on how each medicine would be used.

- On review of patient C's records, we found an incorrect transcription of medication. Although the correct medication had been given to child C, the transcribing error on the chart had not been identified by staff at the service

- Patient C required also required Paracetamol up to four times daily. We found this medication had not been supplied and no review had taken place to assess if it were still required.

- We saw on patient C's care plan that 'not prescribed anti-epileptic drugs' was recorded as part of the assessment. However, child C was prescribed two types of antiepileptic drugs. This meant there was not an accurate up to date care plan reflecting child C's health needs

- We saw patient D was listed as having PRN paracetamol. On review of the record, we found this was not recorded on the medication chart. Patient D did not arrive at the hospice with paracetamol and no documented medicines review was undertaken.

- The 'Transcribing Medicines Procedure' stated that 'medicines should be in original containers'. We found that staff were not following the hospice procedures as children were admitted with medication in domestic use type bags.

- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers did not investigate incidents thoroughly and we found no evidence that they shared lessons learned with the whole team. Recent incidents had not been investigated in line with policy and there was no documented evidence of any learning from the four medication incidents that took place in August and September 2020. Staff told us they were not confident that learning from incidents was effective.

- There had been a succession of four medication errors on four separate occasions involving different staff during August and September 2020 and involving different paediatric patients who were all in Butterwick House for respite care.

- The action plans in response to the recent medication errors included a review of policies by the provider. However, policies and training guidance submitted to CQC were out of date and contradictory. For example, the 'Procedure for the transcribing of children's medicines' was dated October 2006 and had a review date of 2009. The 'Procedure No:13 Transcribing Medication (Children's Unit), dated June 2020, was contradictory to the above procedure. In addition,

recent training material provided to staff stated that two nurses should check in medicines when a child was admitted. However, the Procedure for the transcribing of children's medicines specified the 'nurse in charge' should do this, and the Procedure No:13 Transcribing Medication (Children's Unit) stated that this was the responsibility of the 'admitting nurse'.

- The action plans in response to the recent medication errors stated that nursing staff would have additional training and competency checks. We saw this training was inconsistent and in some files incomplete.

- Concerns relating to poor incident management were highlighted as part of the previous inspection in November and December 2019. We identified that 'incidents were not properly reported and investigated, and learning was not embedded to prevent similar incidents occurring in the future'. We issued a requirement notice to the provider, outlining improvements that must be made to address the failings and by when.

Are Hospice services for children well-led?

Inspected but not rated

- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff did not regularly meet, discuss and learn from the performance of the service. The organisation's quality, safety and risk committee did not have a thorough oversight of risk or incident management, no monitoring of key performance indicators was discussed, and meetings focussed almost entirely on the adult hospice and the wider unregistered elements of the provider's work.

- The provider had submitted an action plan to CQC in response to breaches of regulation identified in the previous inspection in November and December 2019. Review of the action plan and findings on inspection in October 2020 showed that although actions had been marked as completed the implementation of change had not been embedded or sustained.

- A requirement notice for a breach of Regulation 17: Good governance of the Health and Social Care (Regulated Activities) Regulations 2014 was served after the previous inspection in November and December 2019 stating, 'The provider did not ensure that effective and robust systems were in place to support the management of governance, risk and performance'. We found no evidence of improvement at this inspection.

- Leaders did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and identify actions to reduce their impact. The organisation's risk register was not updated, poorly written and showed no evidence of appropriate mitigation of risks relating to Butterwick House. The greatest risk identified on the governance tab of the risk register was the register itself. Staff did not always follow policies informing the use of the risk register. Leaders gave very different answers when asked what the top three risks were for Butterwick House.

- We reviewed the strategic risk register which highlighted no risks relating to the medicines' incidents, nor any closed incident related risks. The incident reporting and investigation policy document stated on page 7 that "once incident plans have been completed, the Incident Review Group will close the incident and update the incident log. If the group feels that there is an immediate or residual risk, the risk will be escalated to the Chief Executive and Board of Trustees and added to the strategic risk register". There was no escalation of the repeated medication errors onto the risk register.

- Risk descriptions lacked detail and although 20 of these risks, were classed as a high risk they had no mitigations, and no recalculation of risk scores.

Inspected but not rated

Hospice services for children

- We asked for the two most recent sets of minutes from the Quality, Safety and Risk Committee (chaired by a trustee); these were dated May and June 2020. There was no evidence of discussion of risk or incident management other than the risk register required revision.

- We reviewed the notes from the trustees meeting dated August 2020 and there was limited assurance of any discussion on quality indicators and any actions required