Mid and South Essex NHS Foundation Trust

Basildon University Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Basildon University Hospital

Requires Improvement 

Basildon University Hospital is operated by Mid and South Essex NHS Foundation Trust. The hospital provides elective and emergency services to a local population of 450,000 living in and around the southwest Essex area.

Medical wards provided by Basildon University Hospital include general medicine, gastroenterology, endocrinology and diabetes, palliative medicine, cardiology, acute medicine, respiratory, renal, geriatric medicine, stroke with in-reach services provided by dermatology, rheumatology neurology.

Between January 2022 and December 2022 medical care had 30,213 admissions. The specialties with the highest number of admissions during the same period were general medicine (10,700), cardiology (6,376) and gastroenterology (5,611).

We carried out this short notice announced focused inspection of medical care on 12 July 2023.

The service was rated as inadequate following our previous inspection, in January and February 2023. Following our last inspection, we issued a warning notice under Section 29A of the Health and Social care Act 2008 because of concerns relating to poor governance, incomplete risk assessments, incomplete patient records, equipment not being maintained, patients' nutrition and hydration needs not being met and medication not being managed in line with the service's medicines policy.

As this inspection was a focused follow up inspection, we only looked at the key questions of safe, effective and well led. We carried out this inspection to determine whether improvements had been made against the requirements of the warning notice we issued at our previous inspection. Although the service had made improvements against the section 29A warning notice, this inspection did not look at the requirement notices that were issued at the previous inspection. As these requirement notices remain, this meant the ratings were limited to requires improvement.

Our rating of this service improved. We rated the service from inadequate to requires improvement . During this focused inspection, not all breaches identified at the last inspection were reassessed to include all potential improvements. We found:

- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to obtain consent from patients.
- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Our findings

However:

The service needed to continue to embed processes and evidence this improvement through continued audit.

Medical care (including older people's care)

Requires Improvement 

Our rating of this service improved. We rated it as requires improvement. See overall summary for details.

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We noted that patients could access call bells and that staff responded to this promptly during our inspection.

The design of the environment followed national guidance. However, on Edith Cavel ward the placement of full capacity bed (bed used to help improve flow in the hospital at busy times) partially blocking access to the ward and was a potential fire risk. In addition, there was no privacy screen for the patient to maintain their privacy and dignity. We escalated our concerns to the deputy director of nursing and information provided by the trust following our inspection indicated the patient had been transferred to an appropriate bay.

We requested a copy of the risk assessments for the full capacity beds. The trust provided the individual risk assessments for the full capacity bed on Edith Cavel ward. The trust also highlighted that following our inspection they were reviewing the full capacity protocol (FCP) site flow diagram and guidance to support decision making and further work was being undertaken and monitored through the urgent and emergency care programme board.

We identified a patient with a mental health condition on one of the medical wards, which was not physically designed to meet the needs of patients who may be likely to harm themselves or others. Physical risk assessments had been completed and service leaders had put mitigations in place. Staff had access to ligature cutters and additional guidance was in place to support staff if a patient did attempt self-harm.

Staff carried out daily safety checks of specialist equipment. Staff had completed a daily log of checks on suction equipment and defibrillators on the emergency trolley and on all the medical wards we inspected.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to a wide range of appropriate equipment to enable them to treat and care for patients. Equipment and consumables were stored appropriately, and corridors were not cluttered. There were systems in place to ensure the regular maintenance of equipment and the equipment we reviewed was within its service renewal date.

Staff disposed of clinical waste safely. Waste was separated and stored securely before being disposed of safely. Sharps bins were not overfilled and were correctly labelled. Staff stored cleaning equipment securely in locked cupboards on all wards we visited.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score 2 (NEWS2) scoring system to monitor patients and identify those requiring escalation. Staff we spoke with described how they used the NEWS2 score to monitor and escalate patients and the channels available to them for escalation. We saw evidence of escalation, in the patient nursing notes, after an increase in NEWS2 score was recorded.

We reviewed 11 sets of patient records. Staff had completed appropriate risk assessments consistently and identified the mitigating actions where required. This was an improvement on our previous inspection.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. During our inspection we reviewed 11 sets of patient records on 5 different wards. All records showed falls and bed rail risk assessment had been completed. All 11 patients had their weight recorded and pressure ulcer risk assessment completed on admission or within 6 hrs. All patients had nutrition or hydration assessments completed. This was an improvement since our last inspection in January 2023.

Data provided by the service following our inspection showed that there had been 394 falls with harm of moderate or above on medical care wards between January and June 2023. The highest number of falls was on Edith Cavell ward, and the highest number of falls across the medical care wards occurred in January and February 2023, with 70 patient falls recorded for each month. Data provided by the service following our inspection showed staff achieved 100% compliance in June 2023, with completion of patient falls risk assessment documentation on all but 3 wards: Marjorie Warren, Elizabeth Fry and Edith Cavell wards all with a completion rate of 87.5%.

The service had dedicated falls leads and an up-to-date action plan to improve the management of falls across the service as part of their falls strategy.

Data provided by the service following our inspection showed that between 20 June and 1 August 2023, 8 out of the 16 medical wards achieved 100% compliance for patents' pressure ulcer risk assessment completed within 6 hours of arrival to the ward. The wards with the lowest compliance rate were Marjorie Warren Ward (56.3%), Pasteur Ward (66.7%) and Elizabeth Fry ward (68.8%).

The service used an electronic tablet system to complete patient risk assessments. This included the falls risk assessments and tissue viability risk assessments. Venous thromboembolism (VTE) risk assessments were completed on the electronic prescribing and medicines administration (EPMA) system. VTE is a condition that occurs when a blood clot forms in a vein and can include deep vein thrombosis (DVT) and pulmonary embolism (PE). Information provided by the service following our inspection showed that in May 2023, 5 out of the 10 specialties reported 100% VTE risk assessment compliance, with 4 reporting compliance rates of above 90% (between 95.2 to 99.5%) and one speciality with 71.4% compliance. In June 2023 only 2 specialities achieved 100% compliance, with 7 specialities reporting a compliance rate of between 90 to 99% compliance.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff we spoke with explained the process for contacting the on call mental health team, but explained that whilst this service was responsive, it could be some time before a patient received input from the mental health service or to be moved to a dedicated mental health service facility.

Medical care (including older people's care)

Staff shared key information to keep patients safe when handing over their care to others. Staff updated white boards above patient beds with details such as help required with daily living activities. Wards had white boards which were magnetic, and staff used magnetic symbols to display the information. Staff wrote information on the boards and updated the information. This was an improvement since the last inspection.

Shift changes and handovers included all necessary key information to keep patients safe. Staff completed SBAR records to ensure safe transfer of patient information during ward moves. SBAR is an acronym for a communication tool to remind staff to share the relevant information Situation, Background, Assessment, Recommendation.

Staff used electronic screens, visible at the nurse station, to record the dates patient risk assessments had been completed and key dates for review. This enabled staff to have easy oversight.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients we spoke with were complimentary about the quality and choice of food available. During our inspection we noted that all patients, where appropriate, on all wards we visited had access to fresh drinking water which was within reach.

Staff recorded patient's nutritional requirements in their patient record and on white boards above their bed so that nursing staff could clearly identify patients in need of additional support during staff handovers.

Staff interacted with patients during mealtimes on all the wards we visited. Staff chatted with patients during mealtimes even if they did not need support to eat. This made for a positive mealtime experience for patients. This was an improvement on our previous inspection.

Staff used red tray system which was used to identify patients who needed additional support with eating and drinking or required a specialist diet. Staff were able to access adaptive cutlery and plate guards for those patients who needed them.

Following our inspection in January 2023, the service had reintroduced protected mealtimes for all wards. This meant that all non-urgent clinical activity stopped to enable patients to eat their meals without interruption. We observed a member of the nursing staff explaining to a medical team that it was protected mealtime and the medical team left the ward and said they would comeback once the protected mealtime was over.

Medical care (including older people's care)

All the wards we visited had designated mealtime coordinators who were identified by name on a white board beside the kitchen. Staff ensured all patients were sitting up and ready to eat and had the right support in place if required before each mealtime. This was an improvement from our last inspection.

During our inspection, we visited Lionel Cosin, AMU West, Marjory Warren, Lister and Edith Cavell wards. Where appropriate, all patients had fresh drinking water, hot drinks, or juices within reach. Patients who needed assistance with drinking had a red lidded water jug within reach. The red top signalled to staff and volunteers that the patient needed additional support with fluids. Staff used a white board above the patient's bed to show if they were nil by mouth, or on specific fluid or food regimes.

Patients we spoke with told us the food was good and staff offered help if needed. Staff encouraging family members to stay and eat with their loved ones if they wished. We noted that staff and volunteers interacted positively with patients during mealtimes, and that the wards were quiet and well organised.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff completed nutritional records accurately in all appropriate records we reviewed. This was an improvement on our previous inspection.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the patient malnutrition universal screening tool (MUST). We reviewed 12 patient records and found that in all cases where a MUST was required staff had completed this accurately and it was up to date.

Following our inspection, we asked the service to provide MUST audit data from the wards we visited during our inspection. The data showed that between 1 June and 27 July 2023 staff on AMU West, Marjory Warren, Lister, and Edith Cavell wards ward achieved 100% compliance with MUST completion and staff on Lionel Cosin, achieved 94.7% compliance. Audit data showing if the MUST had been reassessed a minimum of weekly or if there was a change in patient's clinical condition showed that staff on all 5 wards achieved 100% compliance with this standard. The service had a nutrition and hydration quality improvement project and action plan in place to address any shortfalls in compliance.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Records we reviewed confirmed where staff identified reducing nutritional intake or nutritional concerns, they referred to the dietitian and the speech and language therapy (SALT) team appropriately. Staff we spoke with told us that therapy teams, for example speech and language therapists, and occupational therapists would support them and were responsive to requests for support.

The service had made some improvements to ensure mealtimes were protected and patients were supported with their nutrition and hydration needs. The service will need to continue to embed protected mealtimes and monitor progress.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with knew the importance of recognising when a patient may lack the capacity to make a decision and the impact this may have on their care and treatment. Staff could confidently describe Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was an improvement on our previous inspection.

Medical care (including older people's care)

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking patient consent prior to any activity and ensuring as far as reasonably possible that patients understood what was happening and why.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed patient mental capacity act assessment and Deprivation of Liberty Safeguards (DoLS) held within the individual patient records. These demonstrated that staff had taken the patients best interests into account and involved family or relatives where appropriate as well as other health care professionals in the decision-making process.

Staff clearly recorded consent in the patients' records. Patient records we reviewed showed that where patients required an MCA or DoLS, staff had recorded this appropriately. Leaders had implemented a new system for managing DoLS referrals to improve the flow of information and ensure the MCA and DoLS were in date and had been reviewed to ensure they reflected the capacity assessment and any restrictions placed on patients. This was an improvement since the last inspection.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Following our previous inspection in January 2023, the safeguarding team had delivered bite size training on MCA for nursing and medical staff. A total of 28 sessions were held across all three sites and 413 staff attended the sessions. On the 15 June 2023, the service held a 4-hour long MCA and DoLS masterclass for staff and other partner agencies and over 150 professionals attended the session. As the bite size sessions were not mandatory, the service was unable to provide details of compliance with the sessions.

MCA and DoLS training were added to the statutory mandatory training list on the services electronic learning platform that went live in June 2023. Information shared by the service following our inspection showed nursing staff achieved 97% compliance with MCA training at level 1 and 95% compliance with level 2. medical staff achieved 84% compliance with MCA training at level 1 and 74% compliance with level 2.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff we spoke with could describe and knew how to access policy and get accurate advice on the MCA and DoLS. Staff we spoke with told us they could access policies and procedures on the services intranet, they could also seek advice from their manager, the services MCA lead, MCA ward champion or from the services local safeguarding lead who would visit the ward routinely.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The trust developed a deprivation of liberty safeguards (DoLS) and mental capacity act (MCA) monitoring process. The ongoing monitoring process reviews DoLS and MCA practice across the trust to monitor the quality and accuracy of DoLS and MCA documentations.

Data provided by the trust after the inspection for the period 1 June 2023 to 14 July 2023 showed staff had reviewed 13 mental capacity assessments. The review showed that 11 out of the 13 included information on the specific question about the decision and also details of the decision makers was clearly identified. The trust safeguarding team reviewed each assessment and provided feedback to the staff member who had completed it to improve learning and drive improvement.

During our inspection we reviewed patients with a MCA and DoLS in place and found staff used approved documentation, that MCA's and DoLS were up to date and reflected the patient's needs.

Medical care (including older people's care)

Patient records we reviewed demonstrated that staff had completed, where appropriate, do not attempt cardiopulmonary resuscitation (DNACPR) forms for patients. Following our inspection, we asked the service for its most recent DNACPR compliance audits for the wards we visited. Data showed that staff on AMU West, Lister and Lionel Cosin achieved 100% compliance, staff on Marjory Warren ward achieved 85% compliance and staff on Edith Cavell 77.1%

The service had made improvements to ensure that mental capacity assessments and Deprivation of Liberty Safeguards were managed in line with legislation and guidance to ensure that required assessments were completed and appropriate actions were identified to protect patients from avoidable harm. The service will need to fully embed the process and progress monitored.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The service had governance structures, which they described as a ward to board process, sharing information and risk form ward level operations to board level oversight.

The service had a governance framework in place to provide oversight of quality and safety performance. Local ward and departmental meetings fed into the specialty quality governance group which reported into the divisional board and into the trust board governance subcommittee and then the services board and met on a monthly basis.

Following our inspection in January 2023, the service had implemented a service wide audit of divisional governance meetings to ensure that the services divisions were using the correct service meeting templates and adopting appropriate governance processes. This was an improvement from our inspection in January 2023. However, the service must continue to embed governance processes and evidence improvement through continued audit ensuring learning is shared across all core services.

We reviewed the service's most recent governance meeting records from June 2023, which showed staff discussed key patient quality and safety issues and concerns to identify any emerging risks and review existing risks across the service. Areas covered included audit outcomes, learning from incidents, staff performance and recruitment, and emerging risks across the service.

The service had an up-to-date risk register, with key actions required to mitigate risk, dates, and staff ownership. We noted that the service had updated the risk register with feedback from our last inspection, demonstrating the service had listened and responded to our inspection feedback in order to improve the quality and safety of the service to patients.

Medical care (including older people's care)

Staff at all levels were clear about their roles and understood what they were accountable for. Since the last inspection, the service had updated the staff clinical governance handbook to provide clarity on the governance structures, systems, and process and this has been issued to senior leadership teams and governance staff and made available on the services intranet. The booklet included information on key governance systems and process, for example management of risk and issues and governance meetings and was a guide for staff in addition to the formal policies and procedures already in place.

Staff of all levels carried out daily, weekly and monthly audits in line with a schedule to monitor the performance relating to all areas, for example, falls risk assessment completion, nutrition and hydration and pressure ulcers. Matrons undertook peer to peer audits. Leaders gave feedback to staff on their compliance with carrying out daily checks and audits, and shared key information on patient safety to minimise ongoing risk of harm. This was an improvement from our previous inspection.

Areas for improvement

Action the trust 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 trust MUST take to improve:

- The service must continue to embed governance processes and evidence improvement through continued audit ensuring learning is shared across all core services. (Regulation 17 – (1) (2) (a) (b) (c))

Action the trust SHOULD take to improve:

- The service should continue to embed protected mealtimes for all patients and promote the opportunity for them to eat and drink safely, ensure that staff meet patients' nutritional, and hydration needs, having regard to the patient's well-being (Regulation 9 – (1(h) (i))
- The service should continue to ensure that mental capacity assessments and Deprivation of Liberty Safeguards are managed in line with legislation and guidance to ensure that required assessments are completed and appropriate actions are identified to protect patients from avoidable harm. (Regulation 11 – (1) (2) (3))
- The service should ensure that it continues to provide suitable premises to care for patients presenting with mental health conditions or those being treated on escalation beds. (Regulation 15 - (b) (c) (d) (e))

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one specialist advisor. The inspection team was overseen by Hazel Roberts Deputy Director of Operations.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance