Care Quality Commission

Mid and South Essex NHS Foundation Trust

Southend University Hospital

Inspection report

Prittlewell Chase
Westcliff On Sea
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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 Southend University Hospital

Requires Improvement 

Southend Hospital is operated by Mid and South Essex NHS Foundation Trust. The hospital provides local elective and emergency services to people living in and around the districts of Southend. Medical wards provided by Southend Hospital include elderly care, acute medical assessment, general medicine, stroke, respiratory, gastroenterology, renal, endocrinology and cardiology.

Between January 2022 and December 2022 medical care had 45,835 admissions including 25,327 day cases.

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.

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 visited 8 wards and observed that on 7 wards, all patients could reach their call bell. Three patients told us staff responded promptly when called. This was an improvement from our previous inspection. However, on Edmund Stone ward, we observed 8 out of 17 patients could not reach their call bell. We escalated this at the time of inspection and service leaders took action to correct the situation.

The design of the environment followed national guidance. Since our previous inspection, the trust had relocated the acute medical unit (AMU) to floor 6 in the Tower Building. Senior leaders explained this was due to ward layout and capacity being better for staff and patient experience. The trust had carried out risk assessments in relation to the environment providing a safe place for staff to care for those patients with mental health conditions. The risk assessment confirmed that windows were of an appropriate standard and had restrictors fitted. However, during our inspection, we observed one side of the window restrictor in sideroom 17, had become misplaced. This was escalated and replaced immediately.

The trust no longer placed full capacity beds (FCB) on Chalkwell or Balmoral ward, this was an improvement on our previous inspection where FCBs had been blocking fire escapes.

Two side rooms have had a full assessment from the Mental Health Liaison Lead Nurse for the Trust with Health and Safety and all ligature points removed or reduced where possible. This was an improvement from our previous inspection.

At the time of our inspection staff were providing care for 3 mental health patients on AMU. All 3 patients had been risk assessed as requiring enhanced supervision. Patient care records confirmed staff had carried out enhanced supervision in line with the recommendations from the risk assessment.

Staff carried out daily safety checks of specialist equipment. On all the wards we visited staff had carried out daily and weekly checks of resuscitation equipment consistently and in line with hospital policy.

Staff could access and had been trained on the use of ligature cutters in all the wards we visited. This was an improvement from our previous inspection.

Medical care (including older people's care)

The service had suitable facilities to meet the needs of patients' families. On Westcliff ward the broken kitchen cupboard doors had been replaced. This was an improvement on our previous inspection. However, on Edmund Stone ward the accessible toilet door lock remained broken. We had escalated this during our previous inspection. We escalated this again and after the inspection the trust shared photos to evidence the door had been fixed.

The trust had closed a large number of estates maintenance jobs and had 450 jobs open at the time of this inspection. This was an improvement from our previous inspection. Staff told us the Estates and Facilities department had become much more responsive.

The service had enough suitable equipment to help them to safely care for patients. We reviewed four pieces of equipment for example hoists, weighing chairs and electronic monitoring devices. All had been serviced and safety checked in line with trust policy.

Staff used clips to attach catheter bags to the sides of patient's beds. This was an improvement from our last inspection where we observed catheter bags on the floor which posed as a risk of infection. This was an improvement on our previous inspection.

Staff provided pressure relieving equipment such as mattresses, chair cushions and heel protectors for patients who were identified as being at increased risk of developing pressure ulcers.

Staff disposed of clinical waste safely. Sharps bins were dated and signed, and staff ensured clinical and none-clinical waste was disposed of correctly. Staff stored cleaning equipment securely in locked cupboards on all wards we visited.

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 system (NEWS2) for adults. Staff recorded patient NEWS scores on a handheld IT device, linked to a centralised patient monitoring system. There were hospital wide outreach services to support deteriorating patients 24 hours, 7 days a week. Nursing staff escalated patients appropriately.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. The trust had developed and introduced a new nursing risk assessment booklet and care plan booklet. This included the new admission booklets with patient details and activities of daily living (ADL) assessment, harm free care risk assessment booklet and the care plan booklet. The trust was moving to documenting care in the medical notes so that all multidisciplinary (MDT) records were in the same place to assist with continuity of care.

We reviewed 9 sets of patient nursing and medical records. Staff had completed appropriate risk assessments consistently and carried out the mitigating actions where required in 8 sets of records. This was an improvement from our previous inspection.

One patient, on Chalkwell ward, was overdue a repeat pressure ulcer risk assessment. This was escalated and rectified at the time of our inspection. However, care rounding records completed by staff, confirmed the patient had still been receiving appropriate mitigating actions.

Medical care (including older people's care)

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for pressure ulcers and infection prevention and control (IPC) in a paper booklet called Harm Free Care Risk Assessment bundle and they completed malnutrition universal screening tool (MUST)and falls risk assessments, including bedrails, electronically.

Data provided by the trust following our inspection showed for the period 20 June 2023 to 1 August 2023 staff had exceeded the trust target (95%) for completed pressure ulcer risk assessments in line with trust policy for all patients on 12 out of 14 medical wards. Two wards had achieved 83% and 90%. The trust had an action plan to continue to improve compliance.

Data provided by the trust following our inspection showed for the period 20 June 2023 to 1 August 2023 10 medical wards out of 15 were 100% compliant with patients having falls prevention assessment completed within 24 hours of admission to the ward. Five wards did not meet the trust target of 90% with the lowest compliance 75%. The trust had an action plan to continue to improve compliance.

Data provided by the trust following our inspection showed for the period 20 June 2023 to 1 August 2023 all medical wards were 100% compliant with patients having bed rails risk assessments completed.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Two sets of records we reviewed confirmed that patients had received input from the mental health liaison team (MHLT) and learning disabilities (LD) nurse. During our inspection we observed a LD nurse providing support alongside nursing staff.

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. Some wards had white boards which were magnetic, and staff used magnetic symbols to display the information. Staff and family wrote information on boards in other wards.

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 Nervecentre, 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. The service made adjustments for patients' needs.

Medical care (including older people's care)

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff provided food and drink for patients including those with specialist nutrition and hydration needs. 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. This was an improvement on our previous inspection.

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 from our previous inspection.

Since our last inspection, the service had reintroduced a "red tray" system, which was used to identify patients who may need additional support with eating and drinking or a specialist diet and staff could access adaptive cutlery, anti-slip mats and plate guards for those patients who needed them.

All the wards we visited operated the protected mealtime. This meant that non urgent interventions, for example physiotherapy or routine blood tests, were not allowed to take place. We observed staff challenging other staff who wanted to approach patients during the lunch time.

All the wards we visited had designated mealtime coordinators who were identified by names on a white board beside the kitchen. This staff member 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.

Two relatives we spoke with confirmed staff encouraged them to stay and eat with their relative. Two patients told us the food was good and staff helped them to cut it up if they needed.

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 from our previous inspection.

Staff undertook a review of food and fluid chart completion as part of the nutrition and hydration audit. In March and April 2023, food charts completion was over 90%. The fluid balance chart completion was 86% compliance. The service had an action plan to continue to improve compliance.

Data provided by the trust following our inspection showed, between 16 June 2023 and 28 July 2023 all medical wards exceeded the trust 90% target for completion of nutrition and hydration records except for Stambridge ward where 87% compliance was achieved. The service had an action plan to continue to improve compliance.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the malnutrition universal screening tool (MUST) risk assessment for each patient we reviewed. The trust had recently replaced their local SUNS tool with MUST.

All the patient records we reviewed confirmed staff weighed patients as part of monitoring their nutritional status either weekly or daily where appropriate. This was an improvement from our previous inspection.

Medical care (including older people's care)

Data provided by the trust after our inspection showed for the period 20 June 2023 to 1 August 2023 staff had completed MUST in line with trust policy for all patients (100%) on 12 out of 14 medical wards. Two wards had not submitted their audit data.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Two records we reviewed confirmed staff identified reducing nutritional intake or nutritional concerns and referred to the dietitian and the speech and language therapy (SALT) team appropriately. This was an improvement from our previous inspection.

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 (DoLS)

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. All the staff we spoke with had a better understanding of the Mental Capacity Act (MCA) and when to assess a patient's capacity. Staff could confidently describe MCA and DoLS. This was an improvement on our previous inspection.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff speaking with patients and gaining their consent before delivering care or treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Patient records we reviewed confirmed staff made best interest decisions for those patients who lacked capacity. For example, for one patient staff used mittens to prevent them from pulling out a feeding tube.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All the staff we spoke with had received bite size training in MCA and DoLS. All staff spoke positively about the training.

The trust had mandated MCA and DoLS training for all frontline clinicians.

Data provided by the trust after the inspection showed nursing staff had exceeded the trust target for completing the training in MCA and DoLS level 1 (95%). Medical staff were at 85% and the trust planned to achieve target by September 2023.

On 15 June 2023, the service held a 4-hour long MCA and DoLS masterclass for staff and partner agencies and over 150 professionals attended the session. This training was not mandatory and the service were therefore unable to provide details of compliance with the sessions.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Site based safeguarding advisors visited wards, at least once a week, to review patients' records to monitor if the most up to date DoLS application and current DoLS status was accurately recorded within the patients' clinical record.

Medical care (including older people's care)

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff described how they accessed advice and guidance on MCA and DoLS through the trust wide intranet and through named MCA champions on each ward.

The trust had introduced a one-page DoLS guidance and brief MCA guidance, 'what a good MCA looks like' guide and 'when to apply DoLS' prompt sheet. Staff told us these were helpful to show them what a good document should look like. We observed the quality and detail of MCA and DoLS paperwork was improved.

Managers monitored how well the service followed the Mental Capacity Act. The trust's safeguarding team 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 accurateness of DoLS and MCA documentations.

Data provided by the trust following our inspection for the period 1 June 2023 to 14 July 2023 showed staff had reviewed 20 mental capacity assessments. The trust safeguarding team reviewed each assessment and provided feedback to the staff member who had completed it to improve learning and drive improvement.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We reviewed DoLS documentation in 9 sets of records. Six records were complete and stored in the patient notes in line with guidance. Three patient records (2 patients on Chalkwell and 1 patient on Paglesham ward) did not have a copy of the extension of the DoLS paperwork present. Staff explained this was due to a delay in the ward receiving it due to the process relying on one person delivering the papers to the ward. However, we were assured staff understood the process around implementing DoLS and what action to take to address the missing paperwork. This was an improvement from our previous inspection.

Staff used teletracking screens, visible at the nurse station, to record those patients who were under a DoLS and key dates for review. This enabled staff to have easy oversight.

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.

Medical care (including older people's care)

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.

Ward and departmental meetings fed into speciality meetings, then the divisional board, care group board and governance and then governance subgroups. These groups reported to the board sub committees, quality governance committee and then the services board and met monthly.

Trust board meeting minutes dated 27 July 2023 confirmed board oversight of trust performance.

The service reviewed governance structures and processes. Senior leaders had increased the frequency of nursing oversight meetings and strengthened the local governance and oversight processes relating to audit and monitoring performance. This was an improvement on our previous inspection. 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 divisional governance board meeting minutes (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.

Staff at all levels were clear about their roles and understood what they were accountable for. The service had updated the Quality 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 is available on the intranet. The booklet includes key governance systems and process such as the management of risks and issues and governance meetings and acts as a guide for staff in addition to the formal policies and procedures.

The trust had provided staff with a power-point user guide which is a step-by-step guide for staff on how to use the electronic audit system (Tendable) and held staff training sessions twice per week. This is an improvement on our previous inspection where we found staff not able to access the audit system.

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. 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.

Medical care (including older people's care)

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 continue to ensure that all staff complete patient records to ensure they are accurate, up to date and legible and that all risk assessments are completed to maintain patient safety. (Regulation 17 - (1(c))
- The service should ensure that it continues to provide suitable premises to care for patients presenting with mental health conditions and ensure all equipment and the estate is maintained and serviced appropriately. (Regulation 15 - (b) (c) (d) (e))

Our inspection team

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