Mid and South Essex NHS Foundation Trust

Basildon University Hospital

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Basildon University Hospital

Inadequate 

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, dermatology, respiratory, renal, neurology, rheumatology, geriatric medicine and oncology.

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 unannounced focused inspection because we received information giving us concerns about the safety and quality of the services of medical care and older people's services. The information of concern related to the quality of care provided including patient nutrition, hydration, pressure care and the management of risks.

As this was a focused inspection, we only inspected parts of our five key questions. We inspected parts of safe, effective, caring, responsive, and well-led.

We did not inspect all the core services provided by the service as this was a risk-based inspection. Basildon Hospital has been rated inadequate overall. As a result of the acquisition, Mid Essex Hospitals location and Basildon and Thurrock Hospitals locations did not retain their location level ratings. When one core service is rated inadequate out of three, this aggregates to an overall rating of inadequate. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

How we carried out the inspection

The inspection team comprised of a lead CQC inspector, an inspection manager, 2 other CQC inspectors and CQC specialist advisor.

During the inspection we spoke with over 30 members of staff and carried out off site interviews with senior leaders, the services falls team, safeguarding lead, tissue viability nurse, dementia lead nurse, and the integrated discharge team. We spoke with 8 patients and 3 relatives. We observed care provided; attended site and staffing meetings, reviewed relevant policies and documents and reviewed 45 sets of patient records.

You can find further 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.

Medical care (including older people's care)

Inadequate 

Our rating of this service went down. We rated it as inadequate because:

- Not all staff had completed mandatory training including safeguarding training.
- The maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always complete and updated risk assessments for each patient to remove or minimise risk. Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date or secure. The service did not always use systems and processes to safely prescribe and administer medicines.
- The service did not always have enough nursing and support staff. Managers regularly reviewed and adjusted staffing levels.
- Documentation of mental capacity assessment were not always decision specific.
- Staff did not always respect patients privacy and dignity.
- People could not access the service when they needed it and waiting times from referral to treatment and arrangements to admit and treat patients were not in line with national standards.
- We were not assured that governance systems and processes were effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.
- We were not assured service systems and processes for identifying, recording and managing risks and performance were effective.

However:

- The service-controlled infection risk well. They kept equipment and the premises visibly clean.
- Staff recognised and reported incidents and near misses. Managers and trained clinicians investigated incidents and shared lessons learned.
- Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. We found that the service had deteriorated since the last inspection in July 2018.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory Training

The service provided mandatory training in key skills, not all medical staff had completed it.

Medical care (including older people's care)

Nursing staff received and kept up-to-date with their mandatory training. The service set an 85% compliance target for all mandatory training, and nursing staff achieved 88% compliance overall. There were 4 modules where the compliance target had not been met, which were learning disabilities level (82%), moving and handling level 2 (61%), conflict resolution - high risk (54%) and adult basic life support (80.5%).

Medical staff did not always keep up-to-date with their mandatory training. The trust provided data for core statutory and mandatory training compliance for the medical and dental staff which showed an overall compliance rate of 56% against a trust target of 85%. Medical and dental staff did not meet the trust compliance target for any of the modules.

The service provided a range of mandatory training, however mandatory training did not include tissue viability, pressure ulcer care and falls prevention. Following our inspection, the service told us it provided additional training that was not part of mandatory training, including face to face training for pressure ulcer management and prevention.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Information showed nursing staff had achieved 87% compliance in dementia awareness and 82% in learning disabilities training. Medical staff had achieved a 47% and 49% completion rate respectively.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with during our inspection told us they received communications about mandatory training that was due and also there was an online area where their mandatory training could be viewed, and which showed training due for completion or requiring updating.

The trust had an action plan in place to improve the mandatory training compliance rate and this was also discussed at the programme board meeting.

Safeguarding

Not all staff had training on how to recognise and report abuse. However, staff knew how to make a safeguarding referral and who to inform if they had safeguarding concerns.

The service set a safeguarding training compliance target of 95%. All staff had to complete safeguarding training every 3 years or as they joined the service. Nursing and medical staff did not achieve the 95% compliance target for safeguarding adults and children training.

Not all nursing staff had completed training specific for their role on how to recognise and report abuse. The compliance rate for safeguarding adults level 2 was 92% and for safeguarding children level 2 was 89%. Not all medical staff had completed training specific for their role on how to recognise and report abuse. Compliance rate for safeguarding adults level 2 was 56% and for safeguarding children level 2 was also 56%.

After the inspection the trust provided information on the adult safeguarding level 3 compliance rate for all staff across the medicine core service. The trustwide data showed that 37% of nursing staff and 18% of medical staff had completed this training. This was not in line with the trust target and recommendation of national guidance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to explain how to make a safeguarding referral, how to escalate this and were aware of the safeguarding leads in the organisation. Between February 2022 and January 2023, staff across the medical wards made 58 safeguarding referrals.

The service's safeguarding lead had established relationships with the local authority and social care teams, as well as the integrated care board which enabled them to discuss safeguarding practices, policy and participate in safeguarding investigations.

The service had up-to-date policies for safeguarding adults and children with clear guidance on how to recognise abuse and make a referral. The safeguarding adults' policy referenced other key policies in relation to safeguarding that staff could refer to, for example the Mental Capacity Act (2005), domestic abuse and stalking and the services disciplinary policy and procedure.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Ward areas had dispensers containing disposable aprons, gloves and masks. Antibacterial hand gel dispensers were available, and posters prompted staff and visitors to clean their hands. Each bay and side room had clinical handwashing sinks and a poster reminding staff of the five moments of hand hygiene.

The service generally performed well for cleanliness. Cleaning staff were trained on how to clean to minimise the spread of infection. Audit data from September to December 2022 showed a compliance of 95% and above.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff worked to a detailed cleaning schedule on each ward. Managers audited cleaning standards and reported areas that needed to be improved.

Staff generally followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below elbows and all grades of staff cleaned their hands regularly. We reviewed the monthly hand hygiene audit between November 2022 and January 2023 across the medical wards. This showed in November 2022 Elizabeth Fry Ward scored below the compliance target at 88% and in December 2022 Lister Ward scored 85.3%. All other wards for the reporting period were fully compliant.

The audit data from November 2022 to January 2023 showed 100% compliance for staff putting on and taking off PPE when entering and exiting patient bays. However, when we visited AMU East, some medical staff did not wear face masks and were not following the trust's infection and prevention control policy.

From April to December 2022, there had been zero cases of hospital associated Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia. There were 31 total hospital-associated Clostridioides difficile (C.difficile) (hospital-onset healthcare-associated C.difficile) cases during July to December 2022.

Following our inspection, we requested the data for the percentage of patients who were eligible for screening for MRSA who were screened within the recommended time frame in Medicine. The trust stated that all emergency admissions were screened for MRSA as per the national guidance and elective patients were risk assessed and screened if required. However, this data was not captured and audited. Therefore, we weren't assured if themes and trends were identified, and action taken.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. During our inspection we noted staff used appropriate cleaning materials when wiping down equipment between each patient use, for example antibacterial wipes. Cleaning staff were proactively engaged in cleaning activities and followed a daily rota with defined areas to complete during their shift. The audit data from November 2022 to January 2023 for equipment cleaning and decontamination showed 100% compliance across the medical wards.

Nursing staff achieved 95% compliance with level 2 IPC training and medical staff achieved 72% compliance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

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 Elizabeth fry ward we found a side room where there was a leak from pipes that had been damaged on the wall. There was a sharps bin collecting the dripping water. A patient was being nursed in this room. This had been reported 3 weeks previously, but no action had been taken to move the patient and close the side room from use. This posed a risk of slips trips and falls and was unsafe. This was concerning and we escalated this to the senior leadership team who told us they would take action. At our unannounced inspection on 7 February 2023 we saw the side room had been closed, and the trust was waiting for parts to be delivered.

On 7 February 2023, we visited AMU west and staff told us they only had 2 working microwaves to heat up patient's meals, instead of 3. This was impacting on mealtimes. This had been reported by ward staff on 2 January 2023 and at the time of our inspection, they were still waiting for it to be fixed or replaced.

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 suitable facilities to meet the needs of patients' families. Visitors were able to park and buy refreshments. The trust published visiting hours and rules on the trust website.

The service had enough suitable equipment to help them to safely care for patients. During our inspection we noted 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 crowded. There were systems in place to ensure the regular maintenance of equipment took place and equipment 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.

Assessing and responding to patient risk

Staff did not always complete and updated risk assessments for each patient to remove or minimise risks.

Medical care (including older people's care)

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.

Audit data for December 2022 demonstrated compliance with the completion of the NEWS2. This audit covered all inpatient wards. The overall results indicate that there was a good and timely escalation of patients that were scoring as high risk on the NEWS2 (7 or more). However, nursing documentation of escalation or the reason for not escalating still required improvement. The trust had an action plan in place to improve performance including increasing awareness amongst the staff team, increasing audit frequency, and identifying any none compliance during normal ward rounds.

Staff did not always complete risk assessments for each patient on admission and did not review these regularly. At our previous inspection in 2021, this was identified as a regulatory breach and the trust was issued with a requirement notice to improve. At this inspection we still found the risk assessments were completed inconsistently.

The service used an electronic tablet system to complete patient risk assessments. This included the falls risk assessments and tissue viability. Venous thromboembolism (VTE) assessments were completed on the electronic prescribing and medicines administration (EPMA) system.

The falls risk assessment should clearly indicate if bed rails were appropriate for the individual needs and requirements of a patient. We saw evidence of bed rails in use when the risk assessment stated they were not necessary and when the assessment had not been completed. We reviewed 45 falls risk assessments, looking at the use of bed rails, across 10 wards and found that 11 assessments were not completed, were overdue or inappropriate. This could put patients at increased risk of falls. We escalated this to the senior leadership team who reviewed the patients and put mitigations in place.

Following our inspection, the trust provided the bed rails risk assessment compliance audit for December 2022. This showed 10 out of 12 wards were 100% compliant with the completion of bed rail assessment. This did not reflect what we found on our inspection. Therefore, we were not assured that the audit data was robust.

At the time of our unannounced inspection on 7 February 2023, a trust wide audit was being undertaken with daily checks on the bed rail risk assessments and monitoring of daily compliance.

The service had a member of staff as the dedicated falls lead and an action plan to improve the management of falls across the trust. One of the actions was to implement a new multifactorial falls risk assessment, and to ensure care plans were in place. In addition, Florence Nightingale ward was trialling sensors with patients at risk of falls. The sensors would alert staff that patients were about to get out of bed and staff could provide assistance to reduce the risk of falls.

Between January 2022 and December 2022, information provided by the service following our inspection showed 1,015 falls had occurred across the medical wards, 32 of which involved patients falling from their bed. The highest number of falls was on Edith Cavell Ward (104), Lister ward (84) and Pasteur ward 78.

As part of our inspection, we spoke with the service's falls lead, who explained that many factors affected the falls rate across the wards, including increased deconditioning of patients with complex health needs. Staff on the wards told us there was an increase in the number of frail elderly patients who were deconditioned or disorientated when admitted to

the wards and needed more time and support to enable them to manage their mobility and ambulatory activity. During our inspection we observed physiotherapists and occupational therapists working with nursing and health care assistants to support patients with their mobility, ensuring they were wearing falls prevention slipper socks when standing, had their mobility aids within reach and offering advice to staff to reduce trips, slips and falls on the ward.

Pressure ulcer risk assessments were not always completed or updated to reflect patient's risk of developing pressure ulcers. Out of the 45 sets of records we looked at, we found 6 patient risk assessments had not been completed, were overdue or actions had not been taken to minimise the risk of these patients developing pressure ulcers. This meant that those patients were at risk because timely assessment had not taken place to ensure appropriate plans of care could be put in place.

Data provided by the service following our inspection showed that between January 2022 and December 2022, the service recorded 183 hospital acquired pressure ulcers, of which 18 were graded as category 1, 113 were graded as category 2, 8 were graded as category 3, and 37 were graded as unstageable. In addition, 7 hospital acquired pressure ulcers were device related.

The highest number of hospitals acquired pressure ulcers were on Elizabeth Fry ward (28), Marjory Warren Ward (24) and Kingswood ward (23). The service had 1 band 7 and 1 band 6 tissue viability nurse (TVN) working within the service. However, at the time of our inspection the band 6 TVN post was vacant. The TVN had a target of seeing new referrals either admitted by the urgent and emergency care department or direct to the ward within 72 hours. However, due to the complexity and number of patients being referred who needed additional support the staff told us that current resources were limiting and did not give them enough time to see all the patients and provide ongoing support to the staff teams.

We saw evidence of venous thromboembolism (VTE) risk assessments flagged red on the trust's electronic recording system, meaning the review was overdue or had not been completed. VTE is a condition in which a blood clot forms in a vein, most commonly in the deep veins of the legs or pelvis. This is known as deep vein thrombosis, or DVT. Medical patients should be considered as being at risk if they have significantly reduced mobility. We reviewed 45 records across 10 wards. Nine VTE risk assessments were either overdue or not completed. Service leads were aware of poor compliance with VTE assessments, and this was being monitored through monthly VTE performance audit. Data provided by the trust for October to December 2022 showed rheumatology was the only speciality that was 100% compliant for all 3 months.

Staff we spoke with knew how to identify sepsis using the electronic patient monitoring systems and use the sepsis checklist to escalate patients who needed additional care. Information supplied by the service following our inspection showed 90.46% of nursing staff and 30.69% of medical staff had completed training on management of sepsis in relation to adults. The electronic patient monitoring system also notified staff to tell them when the sepsis check list was due, or overdue or if the time frame for antibiotic administration was overdue. Following our inspection, the service provided its antibiotic audit covering May to December 2022. The audit showed 100% of patients who triggered for sepsis were given antibiotics within an hour for all months apart from October 2022 which was 88%.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support.

Shift changes and handovers generally included all necessary key information to keep patients safe. Handover information included a range of information about patients covering all aspects of their needs. Handovers included diagnosis, relevant past medical history, treatment plans including observations, outstanding investigations and results,

infections, resuscitation status, mobility, dietary needs, cultural/religious aspects, night-time needs and discharge plan. However, we were not assured that actions were followed through or updated within the patients nursing and care plans as we noted inconsistent patient record keeping where staff had not completed or updated care records to ensure patients' needs were met. For example, 4 pressure ulcer risk assessment scores that had increased were not escalated appropriately, reviewed in timely way or mitigations put in place in line with trust policy.

Nurse staffing

The service did not always have enough nursing and support staff. Managers regularly reviewed and adjusted staffing levels.

The service did not always have enough nursing and support staff. The actual number of registered nurses (RNs) and healthcare assistants (HCAs) on shift did not always match the planned numbers. On all the wards we visited during our inspection, the actual staffing levels for RNs and HCAs were below the planned level. There was an established escalation and mitigation procedure in place for the ward managers to raise staffing issues and concerns. Staffing levels were reviewed regularly by senior leaders and resources allocated accordingly.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance. The service used a nationally recognised safer staffing tool to manage and predict staffing levels. There was close oversight of each area with the matron of the day looking at the skill mix required. Consideration was given to the acuity of the patients and the number of patients in each bay and side rooms.

Managers told us there was an ongoing recruitment drive locally and from overseas to fill gaps within the workforce. However, this also raised a challenge as new staff and those recruited from overseas required additional support. Ward managers also told us this created a challenge to have the right skill mix on each shift.

The ward manager could adjust staffing levels daily according to the needs of patients. Managers planned rotas in advance and worked with other managers to fill any gaps, but sickness and vacancy rates did affect the ability to provide cover. Staff told us it was normal for them to be moved from their regular ward to cover short level of staffing in other areas of the service.

The service had reducing vacancy rates. Information shared by the service following our inspection showed in December 2022, the vacancy rate for RNs was 8.81%. Vacancy rates for RNs had reduced monthly from 20.68% in January 2022.

The service had reducing turnover rates. Information shared by the service following our inspection showed in January 2022, the turnover rate was 12.04%, which has reduced to 9.65% in December 2022.

The service had variable sickness rates. Over the period January to December 2022 sickness rates for nursing staff varied between 3.97% and 7.83%.

The service had variable rates of bank and agency nurses used on the wards. Managers limited their use of bank and agency staff and requested staff familiar with the service. Information shared by the service following our inspection showed in December 2022, the service used 11.6% bank staff and 3.1% agency staff. From January to December 2022 the use of agency staff was decreasing, at its highest in March, 25.6% agency staff was used.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers told us agency staff came with the required training and had a local induction held on the ward. Bank staff were offered the same training and induction as substantive staff and their training was continuously monitored as for permanent staff.

Medical care (including older people's care)

Medical staffing

The service had enough medical staff and managers regularly reviewed and adjusted staffing levels and skill mix.

The service had reducing vacancy rates for medical staff. From January to December 2022 the vacancy rate for medical staff was variable. The vacancy rate for December 2022 was at 4.05% compared with 6.90% in January 2022.

The service had reducing turnover rates for medical staff. From January to December 2022 data showed the turnover rate was reducing from 15.48% in January 2022 to 10.85% in December 2022.

Sickness rates for medical staff were variable. Over the period January to December 2022 sickness rates for medical staff varied between 0.72% and 2.45%.

The service had low usage rates of agency staff. Data provided by the service showed that from January to December 2022 average agency staff use was 3.3%.

The service had a variable rate of bank staff use, with an average rate of 17.9% between January and December 2022.

The service generally had a good skill mix of medical staff. The service had no vacancies among consultants. However, data provided by the service showed a vacancy rate 28.53% for junior doctors.

The service always had a consultant on call during evenings and weekends. There was always a consultant on call out of hours. Out of hours on weekdays, there was a medical consultant onsite from 5pm to 9pm. After 9pm the consultant was on call from home. During the weekend an on call medical consultant was onsite for 12 hours and then on call from home. In addition, the service had other specialty medical consultants on call out of hours and at weekends.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.

Patient notes were not always comprehensive. The service used both electronic and paper records, most staff could access them easily, however, we observed different levels of competency in the use of the electronic tablet, which affected the ability for some staff to access records.

Records were inconsistently completed. We reviewed 45 sets of patient records and found they were not always clear, up-to-date and comprehensive. Staff did not always complete risk assessments and associated care plans in the records we reviewed. For example, 6 records did not have a pressure ulcer risk assessment completed or they were delayed, 11 records did not have a bed rail risk assessment completed, 9 records showed VTE risk assessments were overdue or not completed, 2 records showed fluid balance charts were incomplete and 2 records showed no patient weight recorded.

Electronic records were password protected and only authorised members of staff could access them. Paper records were stored in a lockable notes trolley by the nurse's station.

Following our inspection, we asked the service to provide us with their most recent record audit. The audit showed that documents were completed in line with the trust policy. For example, 97.6% of notes were legible with roles defined, 98.8% of entries were dated and timed, 100% wound assessment completed, and specific individual needs been documented 100%. This did not reflect the findings of our inspection, where we found inconsistencies with the completion of records.

Medical care (including older people's care)

Medicines

The service did not always use systems and processes to safely prescribe, administer and record medicines.

Staff did not always follow systems and processes to prescribe and administer medicines safely. The service used an electronic prescribing and medicines administration (EPMA) system and a mixture of paper charts for the prescribing and administration of medicines. We reviewed 19 prescription records on the EPMA system, and infusion charts and noted 14 omitted or delayed doses between them, including a time sensitive medicine not being administered and one dose administration error. We brought this to the attention of the ward managers during the inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Medicines were reviewed regularly on ward rounds. Clinical pharmacists regularly visited the wards, reviewed medicines and spoke with patients about their medicines when required. Ward staff knew how to contact a pharmacist for advice when necessary. Patients were provided with specific advice about their medication on discharge where appropriate.

Venous thromboembolism (VTE) protocols were embedded into the electronic prescribing system; however, we saw that these were often not completed meaning that VTE risk assessment were not carried out and no VTE prophylaxis medicines were prescribed.

Staff stored and managed all medicines and prescribing documents safely, in line with the provider's policy. The EPMA was locked when not in use to prevent unauthorised access.

Medicines were stored safely and securely within the wards, including controlled drugs (CDs). There was a system in place to ensure medicine use was monitored, and expiry date checks were carried out regularly including emergency medicines trolleys. Ambient room and fridge temperatures were monitored. Medicines cabinets were only accessible to authorised staff and locked when not in use.

Controlled drugs were managed in line with the providers policy, and staff carried out quarterly CD audits.

Staff did not always follow national practice to check patients had the correct medicines. Staff told us that pharmacists regularly attended wards to complete medicine reconciliation. In some cases, an advisory note was left for prescribers in the notes section in the EPMA system. Although in some cases it was unclear whether these were actioned.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicines safety notices were provided on a monthly newsletter which was distributed widely across the trust. In treatment rooms within the wards alerts and incidents were displayed to update staff.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines that were prescribed and administered to manage agitation or aggression were appropriately monitored. Staff we spoke with understood the requirements within the trust policy.

Staff we spoke with could describe what they would do if a patient lacked capacity and refused their medication.

Incidents

Staff recognised and reported incidents and near misses. Managers and clinical staff investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Medical care (including older people's care)

Staff knew what incidents to report and how to report them. Staff we spoke with were able to explain what incidents to report and how to report them using the trust's electronic reporting system. Staff reported serious incidents clearly and in line with trust policy.

Between February 2022 and January 2023, the service reported 26 serious incidents. The wards that reported the highest number of serious incidents were on AMU Osler Ward (5), both AMU Lionel Cosin ward and Kingswood ward reported 3.

The service leaders we spoke with told us one of their challenges was dealing with a backlog of incident investigations and reports that still needed closure. Records from the care group governance meeting on 4 January 2023, stated that there were 242 overdue incidents and 14 serious incidents, weekly meetings were in place to close these down. The highest number of reported incidents in December 2022 related to falls, hospital acquired pressure ulcers, discharge pressure ulcers/on admission and staffing/workforce.

The service had 2 never events in the 12 months prior to our inspection. One was related to a medication administration error where a patient was given an increased dose of insulin. The second related to a delay to treatment/procedure where the patient received the wrong invasive procedure in the endoscopy unit. The service had investigated and reviewed both incidents and shared learning across the service. Both incidents were classed as low harm to the patient.

Managers shared learning about never events with their staff and across the trust. The service had investigated and reviewed both never events and shared learning across the service where it could make changes.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents during ward meetings and the actions and findings from serious incidents were presented at the department of medicine for older people (DMOP) clinical governance group meetings.

Managers and clinical staff, who were trained to undertake investigations, investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate.

Nutrition and hydration

Staff did not always ensure patients had enough food and drink to meet their needs and improve their health.

Staff provided patients with food and drink. 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.

Medical care (including older people's care)

The service did not provide protected mealtimes. During our inspection we noted that mealtimes were busy and healthcare professionals carried out care rounds. This meant nurses and care assistants were not always available to serve the food and give help to patients who may need it. Staff told us since the COVID-19 pandemic, the number of volunteers that help patients at mealtimes had significantly reduced. As a result, patients were not always appropriately supported with nutrition and hydration during mealtimes. We escalated these concerns to the senior leadership team at the time of our inspection.

At our follow-up unannounced inspection on 7 February 2023, we found the trust had relaunched protected mealtimes across all of the medical wards. We observed a red tray system in place, which prompted staff that patients with a red tray may need additional support or assistance with eating their meals or having a drink. Any patient who needed a red tray had this recorded on their patient record, and above their bed side. Host staff we spoke with were clear on their responsibilities in relation to supporting patients to ensure they had the right meals with the aid of a white board in the kitchen area that recorded if patients needed a red tray or a pureed meal. On AMU West ward we saw volunteers supporting patients at mealtimes and staff interacted positively with patients during mealtimes.

Staff did not always provide patients with specialist nutrition and hydration needs. We saw 2 records where patients had been reviewed by a dietitian and prescribed drink supplements and a high protein diet 7 days prior to our inspection. This had not been implemented by the ward staff. We escalated this with the ward manager who took the necessary actions.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. During our inspection we reviewed 45 sets of patient records and noted that in 7 of the records staff had not always completed the patient's nutrition or hydration risk assessment or the patient's food and fluid chart was not completed or escalated appropriately.

On Bursted ward we observed that 2 patients had not been offered lunch and had not been given food. When we returned to the ward, we saw that incorrect information had been entered onto the food charts for these two patients indicating one patient had refused and the other patient had eaten 75% of their lunch. Following our findings, the trust reviewed the documentation for these 2 patients and told us one of the patients had declined their meal but had custard and a yoghurt and that this was documented on their food chart and confirmed by the ward manager. The other patient was able to feed themself and had eaten their meal.

Following our inspection, the trust told us that senior nursing staff would undertake an immediate 'Brilliant Basics' audit on each medical ward, to assess food and fluid charts were being completed and to ensure patient nutrition and hydration needs were being supported during mealtime. The trust also had an ongoing action plan to ensure patient nutrition and hydration needs were being met and this was being monitored through the quality improvement programme board.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to the patient malnutrition universal screening tool (MUST). Following our inspection, the service provided data from its January 2023 MUST audit showing compliance with referral to a dietitian where a patient scored greater than 2 in the MUST score. Thirteen wards achieved 100% compliance and 4 wards did not complete the audit. During our inspection 3 patients' food and fluid charts were not appropriately completed and when patients had not eaten, staff had failed to escalate this. One patient's MUST assessment indicated the patient required a referral to a dietitian. The patient's records showed 5 days later the patient had still not been reviewed by a dietitian. We were therefore not assured that the records in relation to patient care were consistently completed, which could lead to patient harm for example, weight loss and increased risk of pressure ulcers.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff we spoke with told us that dietitians, occupational therapists and speech and language therapists were responsive to their requests for support, but there was a shortage of therapy staff across the service which meant patients had to wait at times for the additional support to be available. Information provided by the service following our inspection showed a sickness rate of 4.24% across the MDT, a turnover rate of 21.93% and vacancy rate of 13.78%. Occupational therapy had the highest vacancy rate of 37.25% and a turnover rate of 24.48%, physiotherapy had a vacancy rate of 7.08% and turnover rate of 24.81%, and speech and language therapy had a vacancy rate of 10.24% and turnover rate of 27.76%.

Pain relief

Staff generally assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff did not always assess patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We reviewed 45 sets of records; the pain assessment tool was not completed in 16 sets of the records and pain scores had not been recorded. The most recent patient record audit showed that pain score was recorded in patient notes 87.9%.

Patients received pain relief soon after requesting it. We observed staff checking on patients' pain levels and asking whether they required pain relief. Patients we spoke with told us that staff would ask them if they were comfortable and provide additional pain relief when required.

Staff prescribed, administered and recorded pain relief accurately. We reviewed patient records and saw that pain relief was prescribed and administered on time. However, 1 patient told us they were not given their pain relief medication on time.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. During our inspection ward managers told us there was an ongoing recruitment drive to fill vacancies within the service. This meant there had been an increase in the number of new and overseas nurses which meant it was sometimes difficult to manage the skills mix on the wards. The clinical educators supported the learning and development needs of staff.

Managers we spoke with told us they give all new staff a full induction tailored to their role before they started work. Local induction was carried out on the wards. The daily nurse in charge checklist audited if induction checklist was completed for all new staff on the ward.

Managers supported staff to develop through yearly, constructive appraisals of their work. Information supplied by the service following our inspection showed that 100% of nursing and medical staff had completed their professional revalidation.

Information provided by the service following our inspection showed 83.55% of nursing staff and 93.58% of medical staff had received an annual appraisal.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily multidisciplinary team (MDT) meetings took place on the wards we inspected. These provided an opportunity for the team to discuss and review patients' treatment and care. There were daily multidisciplinary board rounds where doctors, nurses and allied health professionals discussed patient care. Items such as discharge dates, social backgrounds, occupational and physiotherapy, actions required, discharge paperwork, Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPRs), investigation results, symptom management, medications and specialty reviews needed were discussed. Staff from the discharge team, flow coordinators, as well as site team representatives attended the board rounds to support discharge, capacity and flow, and working as a team to maintain access and flow in the hospital.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked with external services and referred patients to other services where required when they were discharged from hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The mental health liaison team was available for advice and to support ward staff care for patients with mental health needs. Staff told us they felt very well supported.

Patients had their care pathway reviewed by relevant consultants. This was evidenced in our review of patient records and the ward rounds and handovers we observed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health, however the documented reason for assessments was not always decision specific.

Staff did not always carry out an appropriate assessment of patient's capacity to consent to specific decisions about their care and treatment. Staff mainly completed generic mental capacity assessments. This was not in line with the trust policy, national guidance or the Mental Capacity Act (MCA).

The trust had undertaken a trust wide audit to measure compliance with the mental capacity assessment in clinical settings. The audit identified that only 58% applied the Mental Capacity Act to identify the need for an assessment.

Staff did not always understand how to assess whether a patient had the capacity to make decisions about their care. For example, we reviewed 14 do not attempt cardiopulmonary resuscitation (DNACPR) documents. Seven patients had been identified as lacking capacity but only 2 records had an MCA assessment completed. This meant that appropriate actions were not always identified to protect patients from avoidable harm.

The trust's DNACPR audit from July 2021 showed assessment of capacity and the application of MCA documentation required further investigation and analysis of the audit findings. However, there had not been any subsequent audit to review whether compliance had improved.

Where a patient had a DNACPR decision in place this was clearly visible in the patient's records and on the electronic tracker system. We also heard this information being passed on to staff during handovers.

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 interacting with patients and noted they gained consent before any care or treatment taking place. At the time of our inspection the service had a high-level consent audit in place and the outcome of the audit was due to be published in March 2023.

Most staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Following our inspection, information shared by the service showed nursing staff achieved 95.5% compliance with MCA training at level 1 and 91.6% compliance with level 2. Medical staff achieved 74.78% compliance with MCA training at level 1 and 72.38% compliance with level 2.

Managers did not always monitor the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. However, we saw 1 patient had a DoLS in place that had expired but there was no information documented to indicate an extension had been applied for.

Following our inspection, the service told us there was a process that was followed where the ward sends the safeguarding team the DoLS document, and they make sure the documentation is completed correctly and complies with the code of practice before they are sent to local authorities. When the DOLS is first completed it gives the service 7 days for urgent authorisation to inform the local authorities. Nationally local authorities are under pressure to process DoLS and have a huge backlog and they automatically give the service another 7 days authorisation meaning that when the service started the DoLS process they got 14 days DoLS approval.

On another ward staff told us a patient had a DoLS order in place. When we reviewed the patient's record, the DoLS application was not signed or dated and therefore was invalid. The mental capacity assessment was also not dated. This meant that patients were not always having their mental capacity appropriately assessed and the trust was not fulfilling the requirements of legislation and guidance including the Mental Capacity Act 2005. While staff initially sought authorisation to deprive a patient of their liberty in line with legislation there was limited evidence that this was followed up appropriately.

Is the service caring?

Inspected but not rated

We inspected but did not rate caring.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. Staff did not always respect patients' privacy and dignity.

Staff were discreet and responsive when caring for patients, Staff took time to interact with patients and those close to them in a respectful and considerate way. We spoke with patients who all told us that they had been treated with dignity and respect.

Patients said staff treated them well and with kindness. During our inspection we spoke with 8 patients and 4 relatives. All the patients and relatives we spoke with told us that staff were very busy and sometimes would have to wait longer to get a response from staff.

Staff followed policy to keep patient care and treatment confidential. Staff ensured bed curtains were closed when providing care and treatment and we saw nursing and medical staff speak with patients in private to maintain confidentiality.

We also spoke with 2 additional patients who had been transferred to the medical wards as part of the full capacity protocol. We saw patients were in beds in designated spaces in the ward corridor or in the bay areas, so their privacy and dignity could not always be maintained. Staff told us they would temporarily move the patient to a side room if they required privacy. We did not always see privacy screens in place in one ward with full capacity protocol patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw staff supporting patients with mental health needs giving appropriate care and having respectful interactions. Staff showed understanding and a non-judgmental attitude when caring for patients with mental health needs. We observed staff caring for patients with delirium and those living with dementia being calm and attentive to patients in distress.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and relatives, we spoke with told us that staff provided emotional support to them when needed.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout our inspection we observed staff reassuring and comforting patients.

Patients or their relatives could be referred for counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with understood their treatment plan and were able to ask staff questions. Staff took time to talk to patients and their relatives and to update them about the patient's care and treatment plan.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff had access to additional communication aids, for example pictures and symbols and a phone application which could be used for translation services.

Staff supported patients to make informed decisions about their care. Staff supported patients to make advance decisions about their care and where possible these choices were made through conversation between patients, their families, and staff and were recorded in patients' medical records.

Medical care (including older people's care)

Is the service responsive?

Inspected but not rated

We inspected but did not rate responsive.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. There were specialist teams to support patients with mental health conditions, learning disabilities and dementia. These teams visited the medical wards regularly to provide advice and support.

The service used a butterfly icon to identify any patients living with dementia. We saw these used routinely on wards that we visited.

Wards were not designed to specifically meet the needs of patients living with dementia. However, all wards we visited had a secure entry and exit system which aimed to keep patients with dementia, who may be confused, safe from the risk of leaving the ward.

Staff had access to a range of sensory distraction resources, for example twiddle muffs held by patients which they could touch, roll and pull, and toy dolls, which were assessed by staff for appropriate use.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff identified patients' preferences and interests through the completion of hospital passports. Staff worked with patients and their family to complete this document which provided nursing staff with information to help them meet the specific care needs of patients living with dementia.

Managers made sure staff and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation serves and staff explained they had access to a phone application that could also help translation where a patient's first language was not English.

Access and flow

People could not access the service when they needed it and waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Information provided by the service following our inspection showed that between January 2022 and December 2022 the medical care service had 30,213 admissions including 18,096 emergency admissions. Performance in relation to referral to treatment (RTT) within 18 weeks for admitted patients had declined during the same period from 82.25% to 75.69%. Rheumatology had shown a monthly decline from 100% in April 2022, to 58.33% in December 2022.

Medical care (including older people's care)

The service, as part of the Mid and south Essex integrated care services, had developed a respiratory and frailty virtual ward which supported admission avoidance in the community. The virtual ward also supported the discharge of patients from the service.

In addition, an urgent care response team (UCRT) operated 7 days a week and worked closely with the local NHS ambulance trust to avoid hospital admission. The service had a frailty assessment unit that, at the time of our inspection was in the processes of being reviewed and relaunched.

Managers and staff worked to make sure patients did not stay longer than they needed to. Information provided by the service following our inspection showed that the average non elective length of patient stay between January 2022 and December 2022 was 9.32 days and elective 4.41 days for elective.

Managers monitored that patient moves between wards were kept to a minimum. Information provided by the service following our inspection showed that between January 2022 and December 2022, there were 3,777 ward moves at night across the medical wards, the highest being on general medicine 1,934 and respiratory medicine 528.

The service moved patients only when there was a clear medical reason or in their best interest. Managers we spoke with told us they only moved patients when it was safe to do so. Between January 2022 and December 2022, there were 17,141 ward moves across the medical wards, the highest on general medicine 4,796 and geriatric medicine 4,348.

Managers and staff started planning each patient's discharge as early as possible. The service had a proactive team approach to start conversations around discharge planning with complex patients and family before they were medically fit. Most wards we visited had discharge coordinators to facilitate and support ward staff with all aspects relating to the patient journey and discharge. This included transport arrangements, obtaining diagnostic test results, to take out (TTO) medication, obtaining patient discharge summaries, and liaising with families, care providers and external stakeholders. They linked in with the integrated discharge team hub to ensure planned discharges happened in a timely manner. These staff also attended daily board rounds and huddles. There were integrated health and social care teams on the hospital site who also supported discharge planning.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. The service aimed to discharge patients before 11am on the day of discharge and completed a comprehensive discharge summary to support the discharge process. Data provided by the service following our inspection showed that From July to December 2022 all medical wards achieved 100% compliance with completion of the patient discharge summary. None of the wards however managed to achieve 100% of their target for completing discharges before 11am and the highest compliance was William Harvey ward with 21.8% compliance in October 2022.

Data from January to December 2022 showed that the relative risk of patient readmission had decreased from 10.65% in January 2022 to 5.89% in December 2022

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Managers worked to minimise the number of medical patients on non-medical wards. Staff told us that patients in non-specialty areas were assessed and deemed suitable to receive care in those wards. The medical consultants and doctors had a daily list of patients that were placed in other wards so these patients could be reviewed by doctors from the relevant specialty on a regular basis.

Medical care (including older people's care)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There was information on the trust website which told patients how they could raise concerns or make a complaint. The patients we spoke with were aware of the process for raising their concerns with the staff.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with explained that there was a local resolution approach to any concerns or complaints raised. This was encouraged for any concern that could be dealt with immediately and may be resolved quickly by members of staff who were directly involved in the patient's care. Where local resolution was not possible or appropriate, staff told us they would refer the complaint to their line manager. All written complaints received by staff had to be forwarded to the trust complaints department.

Managers investigated complaints and identified themes. All complaint responses were collated by the complaints department and numbers of complaints and any themes were detailed in the patient and liaison service (PALS), complaints and patient experience monthly report. Data from January to December 2022 showed the service had received a total of 98 complaints. The wards with the highest number of complaints were AMU West (11), William Harvey Ward (10) and AMU East (9). At the time of our inspection there where 26 complaints open and waiting for final response.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily 'safety huddles' and at routine meetings to aid future learning. This was evidenced in the meeting minutes.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the service. Priorities and issues were not always managed effectively. They were visible and approachable in the service for patients and staff.

The medical care core service sat within care group 1, division 1 emergency department acute specialist medicine and ward management. Care group 1 was strategically led by a triumvirate made up of a divisional medical director, divisional director of operations and divisional director of nursing. Day to day operations of the service was led by the clinical director, deputy director of operations and deputy director of nursing. Local leadership was provided by matrons and ward managers. Staff told us their ward managers were supportive.

Medical care (including older people's care)

Leaders understood the challenges to quality and sustainability. The leadership team told us the service was managing the ongoing challenges from the COVID-19 pandemic and the increased number of patients with complex needs, which had impacted on the workforce. Leaders told us that staffing levels and concerns about skill mix as a result of an increased number of overseas and junior nurses was having an impact on patient experience.

Most staff spoke positively about the leadership and organisation structure. Staff told us they understood the reporting structures clearly and described their line managers and senior divisional managers as approachable, visible and who provided good support.

There were lead nurses for dementia, tissue viability and safeguarding and a falls lead therapist who provided trust wide guidance and direction on their specialist area. They promoted the implementation of best practice and provided specialist advice. Staff knew about the specialist lead nurse roles and told us these staff were accessible and acted as a useful resource.

Vision and Strategy

The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action.

The service's clinical strategy called 'Your care in the Best Place', had been in place since 2018. The clinical models developed as part of this strategy included medical specialities: Cardiology, Respiratory, Renal medicine, Stroke and other specialties.

Following our inspection, information shared by the service showed that the medical specialties would be working on developing their individual clinical strategies over the next 12 months, to bring them in line with the organisational and quality strategy.

The organisational strategy had 6 strategic objectives for 2022/23, focussed on patient safety, improving access for patients to receive care, enhancing the skill and confidence of the workforce, promoting a respectful behaviour leading to improved engagement and retention, and working effectively with partner organisations to improve population health outcomes. In addition, the strategy was underpinned by the trust values: excellence, compassionate and respectful.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff told us they felt supported, respected and valued by their ward managers and matrons. However, staff felt challenged due to ongoing staffing issues and the impact of the COVID-19 pandemic. Staff were tired and morale was low on some medical wards. Staff worked across different specialisms to ensure safe staffing levels.

Leaders recognised the pandemic had taken a heavy toll on staff morale and work remained very challenging on a daily basis. Ward managers told us about the importance of supporting junior staff and the trust had provided ways to enable leaders to support their staff.

Despite staffing concerns, staff we spoke with were very proud of the service they delivered and described their colleagues as supportive. They told us they had good working relationships. Multidisciplinary team working was evident on all the wards we visited, and we observed mutually respectful interactions between the staff teams.

Medical care (including older people's care)

Staff were patient focused, and the culture was focused on the needs and experience of people who used the services. Staff told us there was good teamwork within the teams and we observed this during our inspection.

Governance

We were not assured that governance systems and processes were effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.

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. Throughout our inspection we found non-compliance in various areas, including the completion of patient records and risk assessments. Leaders told us regular clinical governance meeting had been stopped and was just restarting, but the terms of reference had not yet been finalised. Therefore, we were not assured that the governance framework was fully embedded or sufficiently robust in consistently maintaining standards.

We reviewed meeting records from October, November and December 2022, which showed that staff discussed quality and performance to identify any emerging risks and review existing risks across the service. Areas covered included staffing skill mix and levels, harm free care, falls risks, incidents, pressure ulcer prevalence, shared learning and other key information.

Following our inspection, we requested audit data. The most recent DNACPR audit for BUH was completed in July 2021. The audit identified further analysis was required to ensure appropriate application of capacity assessments. However, there was no evidence this had been followed up. The trust wide MCA audit completed in August 2022 (28 patients) evidenced 26% of the audit group had inappropriate restrictive measures in place. Throughout our inspection, we identified the trust still had ongoing issues in this area. Therefore, we were not assured the trust used audits to monitor and drive improvements in quality.

Ward managers had difficulty monitoring mandatory training on the electronic system. Ward managers told us the figures on electronic training records were not reflective of the actual compliance of staff on the ward. Therefore, managers were not able to monitor mandatory training effectively at a local level.

At our last inspection in September 2021 the service was issued with a requirement notice to improve on completion of patient risk assessments. We identified the same issues on this inspection. Therefore, we were not assured the service had effective processes and oversight in place to ensure good governance throughout the service.

Management of risk, issues and performance

We were not assured service systems and processes for identifying, recording and managing risks and performance were effective.

The service had systems and processes for identifying, recording and managing risks, issues and mitigating actions. The service had an up-to-date risk register, which included risks in relation to staffing levels, non-compliance with mandatory training, increased numbers of falls, patients developing pressure ulcers, alongside other areas of risk. Leaders and managers, we spoke with were aware of the services risk register and which risks related to their respective areas. Risks were regularly reviewed at the monthly governance team meetings.

Medical care (including older people's care)

The service had invested significantly in local ward audit systems to capture performance and risk data at ward level; however, we were not assured that the internal audit systems and processes were effective in relation to staff complying with the internal quality standards, consistent in their implementation and impact on patient care or outcomes.

Areas for improvement

Basildon University Hospital Medical Care

- The service must ensure that all staff complete mandatory training. (Regulation 18 - (1))
- The service must 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 must ensure that mealtimes for all patients promote the opportunity for them to eat and drink safely and ensure that staff meet patients' nutritional and hydration needs, having regard to the patient's well-being (Regulation 9 – (3)(i))
- The service must ensure it has effective governance, risk and performance measures in place. (Regulation 17 – (1-2 (a) (b))
- The trust must ensure that staff prescribe and administer medicines safely. (Regulation 12 - (2(g))

SHOULDS

Basildon University Hospital Medical Care

- The trust should take necessary steps to reduce omitted and delayed dosing of medicines.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, 2 CQC inspectors, and a CQC specialist advisor. The inspection team was overseen by Antoinette Smith, Interim 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
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

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
Diagnostic and screening procedures	S29A Warning Notice
Surgical procedures	
Treatment of disease, disorder or injury	