Basildon and Thurrock University Hospitals NHS Foundation Trust
Basildon University Hospital

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<th>Region:</th>
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| Location address:  | Nethermayne
                     Basildon
                     Essex
                     SS16 5NL               |
| Type of service:   | Acute services with overnight beds |
| Date of Publication:| August 2012            |
| Overview of the service: | Basildon Hospital were one of the first 10 NHS Foundation Trusts in the country and is an associate teaching hospital. Providing an extensive range of acute medical services at Basildon University Hospital and Orsett Hospital, they primarily serve the 310,000 population of Basildon and Thurrock in South West Essex, plus some residents |
of the neighbouring districts of Brentwood (for whom they are the main provider of cardiology services) and Castle Point.
Our current overall judgement

Basildon University Hospital was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 1 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People we spoke with told us that they were happy with the care and treatment they received. We spoke with the parents of four children who were attending the Accident and Emergency department. They told us that they were happy with the care and treatment their children received. One person told us: "We were seen almost immediately. I cannot fault the nurses or doctors here." Another person said: "It can be very busy here at times but we are always seen as soon as possible."

What we found about the standards we reviewed and how well Basildon University Hospital was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard. People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan

Other information

In a previous review, we took enforcement action to protect the safety and welfare of people who use services for the following essential standards:
• Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

In a previous review, we found that action was needed for the following essential standards:
• Outcome 07: People should be protected from abuse and staff should respect their human rights
• Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare
• Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
• Outcome 17: People should have their complaints listened to and acted on properly

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04:
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings
What people who use the service experienced and told us
People we spoke with told us that they were happy with the care and treatment they received. We spoke with the parents of four children who were attending the Accident and Emergency department. They told us that they were happy with the care and treatment their children received. One person told us: "We were seen almost immediately. I cannot fault the nurses or doctors here." Another person said: "It can be very busy here at times but we are always seen as soon as possible."

Other evidence
We carried out this review to follow up on a warning notice we issued in July 2012 about concerns as to how the trust identified and managed acutely ill or deteriorating adults and children.

When we visited Basildon Hospital in June and July 2012 we identified significant shortfalls in how sick children who attended the Accident and Emergency department were assessed and supported. We found that triage assessments were not always carried out within the target 15 minutes. The triage assessment helps to ensure that the risks to the health, safety and welfare of children are identified and prioritised so that children who require urgent treatment are seen and supported in a timely manner. This meant that children did not always receive the treatment they required in a timely manner, which put their health and safety at significant risk.

When we visited the hospital on 01 August 2012 we looked at the nursing and medical notes for all the children who attended the department on 01 August 2012. We saw
that each of the 12 children who attended the department had a triage assessment within 15 minutes of their arrival. This helped to ensure that more acutely ill children were prioritised and seen by the medical teams promptly. The trust provided us with evidence of the improvements made in ensuring that children, who attended Accident and Emergency department, had an initial triage assessment within 15 minutes of their arrival. From records of audits carried out by the trust we saw that between 19 July and 29 July 2012 100% of children who attended the Accident and Emergency department had a triage assessment within 15 minutes of their arrival. This provided us with assurance that staff were providing care that was effectively monitored to ensure children were safeguarded from the risk of unsafe care or treatment.

Basildon Hospital used a system of observations to help recognise when a child's health or condition is deteriorating. A Children's Early Warning Tool (CEWT) was used to assess each child's health condition. When we last visited the trust in June and July 2012 we found that staff in the Accident and Emergency department were failing to carry out these observations effectively, this placed children at significant risk.

When we carried out the visit on 01 August 2012 we saw that CEWT observations were recorded as part of the initial triage assessment for all of the children whose notes we looked at. We saw that the CEWT score was assessed each time that observations were assessed for each child. This helped to ensure that staff recognise when a child's condition was deteriorating and to ensure that acutely ill or deteriorating children received prompt care and treatment.

Basildon Hospital had an assessment system for recognising the deteriorating condition in adult patients. This includes monitoring each patient at risk. The trust had developed a Patient at Risk (PAR) tool to support this. This tool assessed patients' overall health and the risk of deterioration. There were instructions in place for staff to follow if they observed that patients' health had deteriorated.

When we last visited the hospital in June and July 2012 we found that staff on the female medical assessment unit and Marjorie Warren ward were not recording PAR scores consistently or escalating their concerns to more senior members of staff.

When we visited the hospital on 01 August 2012 we looked at the nursing and medical records for seven patients on the female medical assessment unit. We saw that patients' vital signs and Patient at Risk (PAR) scores were carried out effectively and at the required frequency. This demonstrated that patients' care needs were appropriately monitored. There was clear evidence in the medical and nursing notes for two patients who were acutely ill, and whose condition was at risk of deteriorating, that appropriate action had been taken by staff. Staff had dealt with the matter quickly and had involved more senior members of staff. There was also evidence that these patients were reviewed by the medical team so that appropriate treatment was provided promptly. This practice promoted the welfare and safety of patients.

We looked at nursing and medical notes for four patients on Marjorie Warren ward. We saw that the frequency for how often observations of vital signs and Patient At Risk (PAR's) scores were to be carried out were clearly indicated and that staff carried out these observations effectively. We also saw where a patient was assessed as deteriorating and at risk, staff dealt with this quickly and effectively. This helped ensure that patients were monitored for signs of deterioration in their condition and that staff
acted so as to ensure that patients received appropriate treatment in a timely manner.

Our judgement
The provider was meeting this standard. People’s needs were assessed and care and treatment was planned and delivered in line with their individual care plan.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

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