We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Furness General Hospital

Dalton Lane, Barrow In Furness, LA14 4LF
Tel: 01539716689

Date of Inspections: 26 October 2013
25 October 2013
Date of Publication: December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services  ✓ Met this standard
Care and welfare of people who use services  ✓ Met this standard
Staffing  ✓ Met this standard
### Details about this location

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<td>University Hospitals of Morecambe Bay NHS Foundation Trust operates across three main sites- Furness General Hospital (FGH) in Barrow in Furness, the Royal Lancaster Infirmary (RLI) and Westmorland General Hospital (WGH) in Kendal. FGH is a 273 bedded hospital and provides a range of services. There is an Accident and Emergency department (A&amp;E), an Oncology service, a Critical Care Unit (CCU), a Maternity and Special Care Baby Unit (SCBU) and Outpatients department.</td>
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When you read this report, you may find it useful to read the sections towards the back called ‘About CQC inspections’ and ‘How we define our judgements’.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 October 2013 and 26 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health and were accompanied by a specialist advisor.

What people told us and what we found

This inspection focused purely on the maternity service at Furness General Hospital and The Royal Lancaster Infirmary. We have written a report for each separate location and therefore to get an overview of the maternity service provided by The University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) both reports should be read in conjunction with each other.

All the women we spoke with who were using the maternity services at Furness General Hospital expressed satisfaction with the care and support they had received. We were told that midwives were "Understanding". One person told us that staff had "Gone out of their way to explain and talk me through it". People told us, and we observed, that their privacy was respected. Curtains were drawn around beds for privacy and staff asked permission to enter.

Medical and midwifery staff we spoke with were aware of the processes to raise and escalate any concerns or incidents. They expressed confidence in using this system. We found that learning from 'near misses' was being shared. A regular staff newsletter and information posters in clinical areas on the lessons learned from the analysis of incidents helped make sure all staff were kept informed.

We found that staffing and skill mix on the different wards was being continuously reviewed. We saw that staff had moved around the service to help make sure service provision and quality of care was maintained. Women were at times diverted to other Maternity units to enable provision of safe care.

Alterations had been made to the location and facilities of the Special Care Baby Unit (SCBU) at FGH. We found that staff recruitment remained a problem in the long term for this unit. In the short term an effective service was being provided by staff working
additional hours.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Respecting and involving people who use services  ✔ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

During our visits to Furness General Hospital maternity unit we spent time on the antenatal, labour, post natal wards and special care baby facilities. We were accompanied on the visit to the maternity unit by specialist advisers. These were a Consultant Obstetrician and Gynaecologist and a Head of Midwifery/ Supervisor of Midwives. These were senior clinicians and midwifery practitioners who were able to bring their knowledge and experience to support and inform the inspection process.

We spoke with women using the maternity services to get their views on their experiences. There were seven women on the post natal ward when we visited and we spoke with five of them. We asked them about their involvement in making decisions about their maternity care, treatment and support and how their privacy was maintained during their care.

We found examples of how women had been involved in developing service provision. One example was a service called 'Listen with Mother' that aimed to debrief women and help them understand their birth experiences. Another initiative we saw was the morning 'walk round' by the ward manager. This was to allow women to make any comments or raise any complaints. Lessons learned from this were being shared and so change could be made using their feedback. For example visiting times were being reviewed following comments made.

Those using the maternity unit, we spoke with, said their privacy and choices had been respected. We saw staff knocking on side room doors, maintaining dignity whilst transferring women to theatre and making sure it was alright to go in behind closed curtains. There were facilities in single occupancy rooms for parents needing privacy or more support. Mothers told us that they had not been left alone during labour and had their chosen birth partners with them.

We saw on all the wards that there were accessible information leaflets and contact
information for services, groups and support agencies that might be useful to parents. These also stated the services offered and how to complain if someone was unhappy with the service. There was information for women on future birth options after having had a Caesarean Section. Midwives we spoke with were able to give examples of using the Trust guidelines in their discussions with women. Midwives explained that they printed these off and took them into the room with the woman to go through options in a consistent and logical way. They had then recorded the women’s decision in the records. We were told that information could be provided in different formats if needed or requested.

Speaking to women on the ward we found that people had been kept informed about what was happening at different stages of their pregnancies and in labour. We were told by one person that when they had been on the labour ward, “The midwife was really helpful and explained everything to me” and also “They (midwives) went out of their way to explain and talk me through it”. Another person told us that midwives on the post natal ward had been “Really helpful and understanding, they listen to me and have answered my questions, no matter how small or silly they might seem to them”.

One person told us they had been very anxious when their baby had to be taken away from them quickly for treatment. However the midwife on duty had spent time talking with them explaining why staff had done that so quickly and what had been done. The person told us that after that they had felt less anxious as they understood why everything had happened so fast. We saw examples in care records and verbal handovers that individual preferences and changes in care were being explained to people, monitored and recorded.

One person we spoke with had originally chosen to deliver in the nurse led unit at Westmorland General Hospital (WGH) but had been unable to do so. They told us, “There were complications and my community midwife explained why I would need to come here”. They told us, “Lancaster was closer but it was full so I came to Barrow”. They told us they had seen the breast feeding advisor and been given information and leaflets about support groups. They also told us “The midwives have helped with feeding as well” and that “Even though it’s been a bit of a rush coming here it’s been alright and gone well”. Another person told us they had been transferred from Royal Lancaster Infirmary as there had been no neonatal support due to the unit being full. They said this had been explained to them and they understood the reasons.
Care and welfare of people who use services ➤ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

During our visits to Furness General Hospital maternity unit we spent time on the ante natal, labour, post natal ward and special care baby facilities. We were accompanied on the visit to the maternity unit by specialist advisers. These were a Consultant Obstetrician and Gynaecologist and a Head of Midwifery/ Supervisor of Midwives. These were senior clinicians and midwifery practitioners who were able to bring their knowledge and experience to support and inform the inspection process.

During our visits we were able to speak with all levels of the medical staff working on the maternity wards including a locum, junior doctors, two non consultant grade doctors and also the consultant on call. We also spoke with the ward managers and staff midwives on the labour and post natal ward and the special care baby unit.

Doctors spoken with were aware of the use of guidelines and the information systems available for their use to support their decision making. The Trust uses an online system (Heritage) to manage all of their current guidelines and protocols. We were told by medical staff that, "We sometimes print off a copy of the guidelines and show them to the patient's. We find that's really helpful in letting them understand what we are doing".

We found that clinical guidelines had been recently reviewed however we saw that some recent national guidelines had not been incorporated as yet. We saw an example of good practice in that some guidelines had prompts on the front sheet if an occurrence of a particular condition required reporting as an untoward incident. We were told that the guidelines were common to both Barrow and Lancaster sites. We saw that one guideline for the management of diabetes in pregnancy had separate appendices for the different sites. This was in the process of being reviewed and all other guidelines applied wholly across both sites.

We spoke with four medical trainees all of whom described, as part of the Trust induction, the use of the early warning scores to recognise any deterioration in a patient's condition. Two had specific training on the recognition of sepsis and its importance in obstetrics and gynaecology. The on call consultant was able to describe in detail the departmental training and protocol for the recognition and management of a patient with sepsis. On the
medical information notice board there was information highlighting the risks of sepsis, its early signs and the protocol for escalation and management.

All the doctors spoken with were able to demonstrate a clear understanding of how to report any clinical incidents and the type of incident that they would need to report. Some had reported incidents and described the process they used. However medical staff did not describe receiving feedback from clinical incidents and sharing the learning with other medical staff across the Trust. The provider may want to take note.

All the midwifery staff we spoke with were able to clearly describe the process for reporting or escalating an incident or concern. We were given verbal examples of how risks were being captured and proactively managed. For example, steps had been taken to mitigate risk around staffing issues and the transfer of staff and women across the service. Staff told us that learning from "near misses" was shared and we saw evidence of this on notice boards and posters in clinical areas and also a monthly 'lessons learned' newsletter. All the midwives we spoke with were very aware of their responsibilities and felt confident to report issues. Matrons were frequently cited by midwives as facilitating learning for staff arising from any clinical incidents.

We saw that women's individual needs were being assessed in order to meet their needs and protect their rights. We could see from records and from talking with women and staff on the ward that care and treatment was being planned and delivered, wherever possible, in line with their individual care and birth plans. We saw that formal handover sheets had been completed so medical and nursing staff were all aware of women's needs and any changes in condition or management.

We observed effective multidisciplinary handovers taking place at FGH. We saw evidence of midwives seeking advice from obstetricians and vice versa. During the night handover we saw that the Consultant rang in specifically to talk with midwives and medical staff about individual cases and to discuss management plans.

The care management plans we saw showed that women had been given information on different options that were available during the course of their pregnancies. Where people had conditions that needed close monitoring during pregnancy, such as diabetes, we could see this had been done. Medical staff reported that there was good access to more specialist opinions on site as required. They cited the management of pregnant women with diabetes as an example of good joint working with the specialist diabetes nurse.

People we spoke with were happy with the care they received one person said, "I am happy with everything so far, I have had a good night". Another told us that they felt "A bit isolated after all the activity" but that "I have been told to buzz if I want to talk or if I am worried about anything".

Staff we spoke with talked about the women's care and knew their individual needs. They also knew how to get further information about people's needs and the policies and procedures of the hospital. All the midwives and support workers we spoke with said they would know what action to take if they were concerned about the health, welfare and safety of someone using the service. Staff told us that when concerns were reported the systems now in place meant they were kept informed about the actions taken in order to prevent any risks. We were told "I feel we are really good at reporting and escalating now, we want it to be right".
Staffing

Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

During our visits to Furness General Hospital maternity unit we spent time on the ante natal, labour, post natal ward and special care baby facilities. We were accompanied on the visit to the maternity unit by specialist advisers. These were a Consultant Obstetrician and Gynaecologist and a Head of Midwifery/ Supervisor of Midwives. These were senior clinicians and midwifery practitioners who were able to bring their knowledge and experience to support and inform the inspection process.

Midwifery staff told us that staffing levels had improved over the last two years and that, "We used to be on our knees" and that "It's much better than it was, less unpaid hours and doing extra shifts now, it's improving". We were told that "Agency staff really saved the day" because of the sickness levels. Staff told us that they had used the same agency staff for last two years and they knew the unit well. Agency staff we spoke with told us that they worked on the unit on their days off from their permanent job and found the unit to be "A much better working environment". Permanent staff we spoke to were unclear how the working time of agency staff was monitored with their other substantive posts.

Staff told us that they were aware that recruitment was taking place and that a new band five midwife had been recruited and would start work in November. We were told that would be a "Good help". However we were told that skill mix was still a problem, for example, there had been a new support worker on duty one night. Staff said there were many tasks they were not yet trained to carry out and so had been able to do very little. It was also pointed out to us that there were still some shortage of the higher grade midwives. The Head of Midwifery told us that staffing and skill mix were under continuous review but may want to take note.

We saw evidence that staff were being moved around the service to make sure there was appropriate service provision. We could see that at other times women were diverted to other units to enable the provision of safe care. We were told by midwives that the equipment had improved and there was a readiness now by management to provide new equipment. Staff we spoke with described good use of guidelines and a good handover process.
We looked at the off duty records for staff deployment over the last four weeks. Midwifery staffing levels were acceptable. These were in line with current professional and national guidelines. Staff on the wards were able to confirm these levels had been in place. We were told there was 40 hours of dedicated labour ward consultant cover provided. Senior medical staff described to us how they were based on the delivery suite at FGH from nine to five at weekends, although this was not reflected in the job plans we looked at. We were told job plans were under review.

Some medical staff we spoke with described a good Trust and departmental induction for staff and joint teaching sessions with the Royal Lancaster Infirmary. Others had experienced a less structured induction which the provider may want to note. More senior medical staff told us they felt the workload was “manageable” and described collaborative working arrangements as "good". They noted the positive developments that had taken place including that the theatre team were now resident on site. Anaesthetic cover was also provided on site and an epidural service that was able to respond to clinical need. This service was described as “good” but also consultants were available from home and that no problems had been experienced to date.

Medical staff noted that they were being called by the midwives much more often in relation to some basic clinical decision making. They told us that some midwives levels of confidence needed to increase. Midwifery staff we spoke with also expressed some mixed feelings about the support systems in place for them on the unit. Some we spoke with told us they felt they were "well supported" and "listened to". Others felt management had not met their support needs and they felt “vulnerable” as a result of "Poor public perceptions" of the maternity unit. Although staff did note that this was “Slowly getting better” the provider may want to note that there remained some unmet support needs for staff after a prolonged period of scrutiny and change.

The major changes that had been made to the Special Care Baby Unit (SCBU) at FGH had been one aspect of the response to a shortage of specialist staff. Staff in SCBU we spoke with were well aware of the recruitment challenges they faced. We were told that their recruitment efforts were now on an international level to try to get the specialist staff they needed for the long term sustainability of the unit. We saw that SCBU staff at FGH were also working in a relocated unit on the post natal ward that had been much reduced in size, facilities and space. This had a logistical impact as it had reduced the facilities for parents with less privacy.

In the short term, to maintain an effective service, the staff were working extra shifts to make sure the SCBU unit was safely staffed. This was only an interim solution. Staff described "Slipping behind" other similar units. Working additional hours to maintain a safe service meant that staff had limited opportunity to make sure they met their own personal development needs. Senior staff explained that they had little management time that impacted on their leadership roles.

We observed and staff told us about the challenges they faced working in an area short of permanent staff. On a day to day level staff were often unable to take meal breaks and additional hours impacted on their life outside work. In the long term this could be detrimental to individual's health as people described feeling stressed and anxious at work. We also saw that little long term consideration had been given to supporting and so retaining the current staff who were keeping the service going. We saw that staff and management were doing what they could to maintain a safe service and recruit the right staff but the provider should note that this may not be sustained in the long term.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✔ Met this standard

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - 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.

**Moderate impact** - 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.

**Major impact** - 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.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.