# Review of compliance

University Hospitals of Morecambe Bay NHS Foundation Trust  
Furness General Hospital

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| Location address: | Dalton Lane  
                    Barrow-in-Furness  
                    Cumbria  
                    LA14 4LF |
| Type of service: | Acute services with overnight beds |
| Date of Publication: | September 2012 |
| Overview of the service: | The Trust operates from three main hospital sites: Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital.  
Accident & emergency departments, critical/coronary care units, maternity services and consultant led beds are available at Barrow and Lancaster. All |
| three sites provide a range of planned care including out-patients, diagnostics, therapies, daycase and inpatient surgery. In addition local outreach services and diagnostics are provided in the community. |
Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

**Furness General Hospital was meeting all the essential standards of quality and safety inspected.**

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 to check whether Furness General Hospital had taken action in relation to:

- Outcome 04 - Care and welfare of people who use services
- Outcome 13 - Staffing
- Outcome 14 - Supporting workers

**How we carried out this review**

We reviewed all the information we hold about this provider, carried out a visit on 14 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

**What people told us**

This unannounced inspection along with a second one at the Royal Lancaster Infirmary (RLI) on the 13 August 2012 focussed on the accident and emergency department including the medical assessment unit (MAU).

During our visit to Furness General Hospital (FGH) we spoke with six people using the service and three of those had come into hospital via the A&E department. The people we spoke with were complimentary about the care they had received from staff in A&E.

Another person told us "They (A&E staff) have been wonderful" and "the nurses have infinite patience" and "the food is very good."

Another said "I can't fault anything."

As part of our inspection we spoke with stakeholders such as the local council's Overview & Scrutiny Committee who have a duty to look more closely into public services outside their own organisation, which includes local NHS hospitals. They said they had not received any concerns from the public about the accident and emergency departments in recent months. They told us they had regular meetings with senior staff at University Hospitals of Morecambe Bay Trust which kept them up to date with any changes in service.
provision at the trust. They were fully aware of the issues in the past that had led us to issue a warning notice.

We also spoke with the Local Involvement Networks (LINks) who had also not recently received any issues or concerns from the public about the emergency departments.

We inspected FGH to check compliance with a warning notice served in February 2012 and to follow up compliance actions from the last inspection report. We had issued warning notices and compliance actions across FGH and RLI for the provision of emergency care.

A separate report has been written for RLI. Although the previous reports highlighted some different issues for each site there were common themes identified across both so it is beneficial to read this report in conjunction with the one for RLI.

What we found about the standards we reviewed and how well Furness General Hospital was meeting them

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

The Trust was meeting this standard.
People experienced care, treatment and support that met their needs and protected their rights

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The Trust was meeting this standard.
The trust had taken steps to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed to meet people's needs.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The Trust was meeting this standard.
People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Other information

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
At our unannounced visit on 14 August 2012 a person told us that despite having to wait for a bed on the Medical Assessment Unit (MAU) that "Everybody has been really great and they have explained everything." and "The woman in charge is fantastic."

Another person who had come into the hospital via A&E was very quickly transferred to MAU. They told us they had been kept in for observation. They were waiting to see the cardiologist prior to discharge and told us "They (A&E staff) have been wonderful" and "the nurses have infinite patience" and "the food is very good."

One person who had come into the A&E department at FGH on the day before our visit, when the department had been very busy, told us they were taken straight through to a cubicle and treatment commenced straight away. They told us "The nurse was very clear and explained what was happening."

We spoke with people about their journeys from accident and emergency to admission onto wards. One person who came into A&E through a referral from their GP waited for half an hour before being taken through to a cubicle and waited there for two hours and was then transferred to the Medical Assessment Unit (MAU). They said they had expected to come straight to the MAU but there wasn't a bed available at the time.

A person who had been admitted on the 13 August 2012, when A&E had been very busy, told us they were taken straight through to a cubicle and treatment was commenced straight away. They told us they had begun to feel uncomfortable in their
chest and told the nurse. Following this they told us that they had promptly received an Electrocardiogram (ECG). They told us they had been transferred to MAU for observation and were due to be discharged to be followed up by their GP. They said; "everybody has been so good" and "there are excellent cleaning practices." They told us that from their own observations whilst on the MAU everybody was being very well cared for”.

Other evidence
We last inspected the A&E department, ward 3 and the medical assessment unit (MAU) on 20 February 2012 when we found moderate concerns around the care and welfare of people using the service. We saw a number of people who had not been monitored appropriately. The department used an early warning score (EWS) Action Algorithm which should ensure changes in a person's vital signs (pulse rate, blood pressure and respirations) were monitored and concerns were escalated to senior clinical staff in a timely manner. However we saw that for three people these vital signs had either not been recorded frequently enough or the scores had not been added up correctly so that the person had not received the right level of observation.

We saw a lack of privacy and dignity where an elderly person exposed himself by removing the bedclothes. There was also a lack of safety where bed rails were in use but there were no protective cushions in place with them to stop a patient putting their legs through the bars and injuring themselves. A person was seen not to be adequately supported or given information during a procedure for lifting and handling when he needed to be moved using a hoist. During this time the person also needed to use a bedpan but no facilities were made available for him to wash his hands after using the bedpan.

The trust wrote to us and told us what it was going to do to address the issues we raised across Furness General Hospital (FGH) and The Royal Lancaster Infirmary (RLI). It was increasing the frequency of spot checks by senior staff to ensure that protocols for the use of observations were being followed. This was to include additional peer review spot checks by matrons. On the spot re-education and training was to be undertaken if non-compliance was identified linked to performance management. The trust had appointed an unscheduled care manager to support the patient flow bed management and monitoring of emergency standards of care across the trust. A clinical site manager would oversee and liaise with night co-ordinators regarding patient observations.

The trust had also increased the number of staff on duty particularly around peak times.

We looked at the way the department was laid out to promote privacy for people using the service. We saw bays had good coverage by curtains to maintain privacy during examination or treatment. We saw that people’s privacy and dignity was being promoted by nursing and medical staff. Within the treatment bays we heard people were appropriately addressed before any treatment or procedure was undertaken and doors were closed or curtains drawn when staff were about to examine or treat people.

We observed examples of good practice and care as staff attended to people in a caring and respectful manner and answered people’s questions even when the department became busier.
We found patient and visitor information leaflets were available and people were able to take information to refer to from display units in the waiting and treatment areas.

The majority of people including those who came in via ambulance came into the department through the main A&E entrance. People who required resuscitation came in through a separate entrance that led directly into the area with resuscitation facilities. Previously all ambulance arrivals used to come in through the resuscitation entrance. This practice was stopped as it was disruptive and did not promote privacy and dignity if the resuscitation bed was already in use.

Additional people requiring resuscitation were seen in curtained bays within the department. These had been appropriately equipped to provide that type of emergency treatment.

We asked for information and records on how people's physiological vital signs (temperature, pulse, respirations, blood pressure) were monitored and recorded by all clinical professionals. We looked at the EWS system and the policy and the procedures in place for ‘physiological observations tracking and the trigger systems’ (POTTS). We saw from records that these observations had been closely monitored and audited weekly by senior staff. Speaking with senior staff and nurses and from looking at the audit records it was clear that this was being strictly monitored. Staff were being spoken with straight away if they were found not to be completing observations as per the EWS system guidance. If there was no improvement in staff performance then it was being treated as a disciplinary matter.

Records on the unit we saw showed that there had been much improvement in staff compliance. On one late shift we saw that an incident form had been completed regarding meeting EWS charts due to the high level of activity in the department that particular day. Trust policy documents identified NICE guidance CG50 2007 ‘Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital’. The trust policy document set out the minimum outcomes expected against the NICE document and the audit tool used the NICE guidance as the basis for their checking guidance.

We looked at shift reports before, during and after our visits. We found there were still problems around the smooth flow of patients through the departments especially at FGH as staff were working with very little extra capacity in the system. For example we saw from reports there were times when there were no medical beds as found on the early shift 29 July 2012 and the late shift 30 July 2012 when three patients breached the four hour waiting time. We also saw breached waiting times because of a lack of high dependency beds on the late shift 29 July 2012. On the 2 August 2012 there were again no beds and staff had also recorded that medical assessments were coming in to the A&E department on the early and late shifts as there were no available beds on the MAU.

Staff told us the main problem was with medical and surgical assessment patients. One member of staff said, "MAU sometimes can end up partially as a general medicine ward." Staff we talked with told us they believed the number of people attending A&E was increasing.

Waiting time targets for the emergency department were not being met and the
department’s performance summaries and shift reports showed this. There was a screen inside A&E that included current performance against the national quality indicator for four hour waiting times. At the time of our visit it read: performance this month, 89.28%; performance this week, 84.62%. Performance over the month had not met the national target of 95% for the total waiting time from admission into A&E to discharge or transfer to a ward. We were also shown the monthly performance summaries for the last few months which showed that targets were routinely not met at FGH. All staff we spoke with said that the numbers of people coming through A&E was steadily increasing and this meant the department was regularly reaching capacity and beyond.

We saw that meetings took place a minimum of three times a day at both sites for monitoring bed capacity and to try and relieve any problems and plan ahead where possible. We saw at the midday bed meeting that there were 23 people accommodated on wards that did not normally look after the particular diagnosis of that patient because beds on the right speciality were not available. This activity was monitored at daily bed meetings and weekly at the Divisional Management Team Meetings to help ensure the needs of these patients were met. One aim of the meeting was to focus the clinical teams on those areas under greatest pressure during the day and we could see there was a team approach being taken to resolving issues.

Shift reports from A&E that we looked at from 29 July to 7 August 2012 showed that patient flow was an ongoing problem with resulting breaches in waiting times for patients.

We spoke with staff of various grades and disciplines and their comments indicated that the MAU was usually full to capacity. There were often delays in transferring people from MAU because there was not space on other wards. If the MAU is routinely full, it can be difficult for staff to find appropriate beds on other wards.

We saw the MAU was full by 3pm on the day we visited. This meant that people were waiting in A&E cubicles for transfer to MAU because there are no available beds there. When A&E runs out of space, a room in the fracture clinic, around the corner from the main department, can be opened and used. This had been done the day before. This is not ideal as it is isolated from the rest of A&E and draws staff away from the department. Staff told us, and we could see from the department layout, that there was nowhere to treat minor injuries and there was regularly an overspill of patients. The trust told us that the fracture clinic was generally only used after 5pm or at weekends when there was no clinic running. The decision to use the fracture clinic was taken by the medical and nursing team on duty at the time. A nurse and a doctor or nurse practitioner ran the clinic. They told us that there would only be two or three people at a time in the clinic / waiting area and they would only see people with minor injuries. The trust told us that the fracture clinic was generally only used after 5pm or at weekends when there was no clinic running. The decision to use the fracture clinic was taken by the medical and nursing team on duty at the time. A nurse and a doctor or nurse practitioner ran the clinic. They told us that there would only be two or three people at a time in the clinic / waiting area and they would only see people with minor injuries. The fracture clinic was part of the emergency department so the existing risk assessments that were in place applied to the opening of the fracture clinic as well. The trust told us that senior staff monitored the situation whenever they had to open the clinic.

We asked senior medical and nursing staff how improvements to capacity and demand at FGH were being addressed. We were told that the situation had been highlighted by the trust and that business cases and financial plans had already been developed to address this. We looked at a report commissioned by the trust on ‘Transforming Unscheduled Care at FGH.’ This detailed how improvements could be made to patient
flow, how to meet capacity and demand in the future, improving assessment and triage processes, revised models of care around medical admissions and emergency surgical pathways and outlined the core principles of the models of care. We saw evidence of discussion around these issues in trust board minutes. We could see from the plans in place and from what nurses and clinicians told us that the approach now being taken was an integrated one where departments were working together to try to solve capacity problems rather than look at capacity issues in their departments in isolation.

The areas for change reported in the 'Transforming unscheduled care' document for FGH were only in the very early stages of implementation at FGH so a definite assessment of the effectiveness of measures being taken could not be made at this visit. For example the collaborative work being done between primary care assessment and the clinical decisions unit to provide one point of access had only been in operation for a week. This was due to be evaluated after three months. There was a weekly meeting to review the development of unscheduled care but this was very much in its early stages. It was clear from what staff told us that matters were being moved forward at FGH and staff voiced to us their commitment to implementing the changes. There is an urgent need to progress this work to transform unscheduled care at FGH without delay. Changes where however in the early stages at FGH in comparison to the RLI.

Our judgement
The Trust was meeting this standard.
People experienced care, treatment and support that met their needs and protected their rights
What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement
The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
No comments were received relating to this outcome form people using the service.

Other evidence
We inspected this outcome at Furness General Hospital (FGH) as much of the information was linked with Royal Lancaster Infirmary where we had issued a warning notice previously.

When we arrived at FGH the department was quiet. We were told by staff that it had been very busy the day before.

Staff told us that on an early shift there was usually five staff and on the late shift there was usually a sister and four 'band 5' nurses. We saw on staffing rotas that was what was planned for with some shifts covered by bank staff. Staff confirmed that there had been additional support recently including an extra clinical support worker (CSW). However they told us the CSWs being sent to the department had not always fully completed their training and therefore could not do all the necessary tasks. For example, signing for observations. Shift reports from A&E indicated that this was so, for example on the night shift 2 August 2012 the reports showed two support workers on duty, neither had computer skills and one was new with limited clinical skills. The report noted that neither could do observations or electrocardiograms (ECG's). On the night shift of 31 July 2012 neither the bank nurse nor the two support workers could use the computer. These problems with skill mix were still there on the night shift for the following night 3 August 2012 and had not been effectively dealt with.
We spoke with medical and nursing staff working on the unit and they told us: "Staffing levels – can be a real problem at times.; "Some days it is OK but at other times when it is very busy, staffing isn't sufficient."; and "Over time it has been getting busier and busier and people are getting more acute. This is an issue because more people are needing 1:1 support. There is also an ongoing problem with people coming in that really need GP care."

A nurse staffing review had just been undertaken and was ready for presentation to senior managers. This review put forward plans for a better skill mix with more suitably trained support workers in the A&E. The matron told us they were presenting a case to get a nurse practitioner for the department and this would allow them to see minor cases, reduce pressure and hopefully improve the flow through the department.

Shift reports showed us that the trust was not always managing to cover every vacant shift, for example on the late shift 30 July 2012 it was recorded that there was a staffing shortage with only four nurses in the department. One member of staff was covering triage and there were two people on half hourly observations. Staff had noted in the report that "it was difficult keeping up with EWS charts." Shift reports showed us uncovered shifts such as 6pm to 2pm with no cover on 29 July. Staff had also recorded "nurse staffing shortage in ED (emergency department)." Senior staff told us that all shortages were monitored and reported on.

There had recently been a significant recruitment drive and senior staff confirmed that 45-50 new clinical staff members had been recruited to work within the emergency departments and medical wards across the trust. Currently a number of these new recruits were awaiting final security and professional checks before commencing work. Staffing levels were being maintained in the meantime through the use of agency or bank staff.

We saw that the staffing escalation plans provided more clarity for staffing generally and in A&E. This was designed to be a proactive plan for both FGH and RLI sites so that at times of increased pressure there was consistency of care delivery.

**Our judgement**
The Trust was meeting this standard. The trust had taken steps to ensure there were sufficient numbers of suitably qualified, skilled and experienced persons employed to meet people's needs.
Outcome 14: 
Supporting workers

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

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement
The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
No comments were received relating to this outcome from people using the service.

Other evidence
We inspected this outcome at Furness General Hospital as much of the information was linked with Royal Lancaster Infirmary where we had issued a warning notice previously.

We asked staff about how training was planned and monitored to make sure staff were kept up to date and that they received the required mandatory training.

Overall, staff working in A&E reported a positive and supportive working environment. They told us they felt happy with their appraisal system and they were supported to access training they wanted to do. However, people did tell us that sometimes it was difficult to make the time to complete training as the department was often so busy. We saw from training and development records that out of 34 staff (this was across RLI and FGH) only nine appeared to have a completed appraisal for 2011/2012. However we saw that appraisals were ongoing for this year and dates for outstanding ones were in place.

At our unannounced inspection on 14 August 2012 we looked at training records for staff working in the emergency departments, which showed that work was ongoing to ensure all staff completed mandatory training for this year. Training matrices showed attendance and had identified training needs for individuals as well as pinpointing dates for future attendance. We saw three examples of portfolios containing certificates of
attendance for three members of staff, which identified what training was required and if something was not needed it identified the reason why. All nursing staff had received moving and handling training and basic life support which was done on an annual basis. Other examples of training having been carried out were child protection, information governance, intermediate and advanced life support (adults and children) and caring for people on blood transfusions. We saw from training records that all new starters had completed a corporate induction which included mandatory training such as moving and handling. They were also given mandatory training workbooks to work with and complete. These we were told were reviewed with the member of staff on a regular basis to ensure they were completed within a specified timescale.

All staff had a completed equipment training record which showed what type of equipment they would use and showed that they had received training on how to use it. The training log also showed that the individual member of staff had been signed off as competent to use the piece of equipment by a senior member of staff.

There were currently no nurses trained in paediatric emergency medicine working in the A&E department. We asked senior medical and nursing staff about this and were told that discussions were ongoing with the paediatric matron to explore options. Currently the children's ward send additional staff (who had experience of nursing children) to support A&E as and when needed and staff told us they had good support from paediatric clinicians who came to see children on A&E.

We spoke with nursing staff and with one person who had a particular interest in working with children. They told us they were due to start an Advanced Certificate in Emergency Care for Children. This person also acted as the safeguarding link for children within the department.

We asked staff at FGH about mandatory training. They told us that "There isn't much protected time to do this, but we got some time last week to do the bed rail training." Another member of staff told us that mandatory training is all online with each member of staff having their own account. This included infection control and fire safety. The most recent e-learning course was proper management of bedrails. We were told that once the new recruits were in post there would be more time to meet training obligations.

**Our judgement**
The Trust was meeting this standard.
People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.
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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| Postal address           | Care Quality Commission  
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