University Hospitals of Morecambe Bay NHS Foundation Trust

Furness General Hospital

Inspection report

Dalton Lane
Barrow In Furness
LA14 4LF
Tel: 01539716689
www.uhmb.nhs.uk

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Furness General Hospital

Inspected but not rated

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below:

Lancashire and South Cumbria.

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.
We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care.
We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered the all of the North West area, including Lancashire and South Cumbria, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services.

However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers.
People who called 999 for an ambulance experienced significant delays.

Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

Our findings

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night.

Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

Furness General Hospital is operated by the University Hospitals of Morecambe Bay NHS Foundation Trust. It provides emergency care to around 350,000 people across North Lancashire and South Cumbria. We visited Furness General Hospital as part of our unannounced inspection during 08 to 09 March 2022.

The Medicine care group manages medical care and the urgent and emergency department. Furness General Hospital medical care consists of general medicine and care of the elderly as well as specialities such as cardiology, oncology, and stroke. There are five medical wards at Furness General Hospital including the acute medical unit (AMU) and the coronary care unit (CCU). During our inspection of medical care and care of the elderly we visited the AMU, CCU, ward 6, the acute stroke unit, ward 7, ward 9 and the discharge lounge.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. During our visit our inspection team spoke to patients' relatives and staff which included consultants, junior doctors, nurses, nurse consultants, pharmacists, discharge coordinators, house keepers and nursing students. We also spoke to the associate director of nursing, the associate director of operations and the clinical director.

At the inspection in April 2021, medical care at Furness General Hospital was inspected but not rated. The last time medical care at Furness General Hospital was inspected and rated was in December 2018 it was rated good all in all domains and rated good overall.

At the inspection in August 2021 urgent and emergency care was rated as requires improvement overall.

As this was a focused inspection at Furness General Hospital, we only inspected parts of our five key questions.

Medical care (including older people's care)

Requires Improvement ↓

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

- The service generally had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always follow best practice when prescribing, giving and storing medicines.
- The services did not have enough medical staff with the right qualifications, skills, training and experience to be compliant with national guidance. However, due to consultants working overtime and flexibility of other grades of medical staff, patients were kept safe from avoidable harm and there were sufficient staff to provide the right care and treatment.

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Mandatory training was comprehensive and covered topics such as infection prevention control, conflict resolution, fire safety, equality diversity and inclusion, health and safety and information governance.

Medical care (including older people's care)

Mandatory training was delivered in a mix of face to face and e-learning sessions, staff received electronic reminders when they needed to complete training.

Overall compliance for mandatory training nursing staff and allied health professionals was 97% against a target of 95%, for medical staff the compliance was 98% against a target of 95%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers were able to monitor staff mandatory training on an online dashboard, they were alerted when a member of staff needed to update training. There was also an education team who monitored mandatory training and reminded staff when they needed to complete training.

There was a manual handling training champion who offered advice to colleagues and signed them off as competent once they had observed them carrying out the correct techniques.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had safeguarding policies for both adults and children. Staff received safeguarding training as part of their mandatory training and knew how to report a safeguarding concern.

Staff were able to give examples of recent safeguarding referrals and the processes they followed. If a staff member had a concern, they would raise it to their ward manager who would then liaise with the safeguarding team and relevant bodies to protect the individual. This was in line with the trusts safeguarding policy.

Staff told us that the safeguarding team were visible on the wards and would help with any questions or concerns.

Staff told us that they would liaise with the mental health team to review patients who were at risk of suicide or self-harm, the team would review the patient within 24 hours and would formulate a plan going forward, which would take into account future care and how the patients discharge would be managed. Staff also had scenario-based ligature awareness training so that they could support patients who were at risk of self-harm.

Staff were able to recognise patients who needed a Deprivation of Liberty Safeguard (DoLS), the Deprivation of Liberty Safeguard is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm. If a patient was on a DoLS and needed one to one care to keep them safe, a registered nurse could be taken off the ward floor and their position would be filled by a bank member of staff.

Nursing staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Nursing staff received training specific for their role on how to recognise and report abuse.

Ward managers told us that safeguarding alerts, referrals and DoLS were discussed at huddles and handovers so that staff could be made aware of any changes to care. We observed a handover were patients who had a DoLS were discussed and what care plans had been put in place.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Medical wards were visibly clean and we observed staff cleaning during our inspection. However, cleaning schedules were not always completed and the use of I am clean stickers varied between wards.

There were hand wash sinks in all clinical areas which displayed the “five moments of hand hygiene”. Sinks were visibly clean and there was adequate supply of soap and paper towels.

We observed that staff adhered to the bare below the elbow policy and also carried out hand washing and sanitising before and after patient contact.

Staff completed infection prevention control as part of their mandatory training, there was a 100% compliance for staff.

There were hand sanitiser dispensers at the entrance of each ward and throughout the wards at nurse stations and on bays.

Staff carried out the correct donning and doffing of personal protective equipment (PPE) when seeing patients, there were posters on display which outlined the correct procedure.

Each medical ward had a clean and dirty utility which was locked, these rooms were visibly clean and organised.

Medical wards carried out a number of different monthly infection, prevention and control (IPC) audits which included hand hygiene, environmental and commode cleaning. These audits looked at areas such as whether the environment was visibly clean and clutter free, whether the commodes were visibly clean, and whether equipment was clean and in good working order. Medical wards’ cleaning scores had achieved a compliance of 97% in February 2022. Cleaning score compliance for January was 97% and 95% in December.

Patient who were COVID-19 positive or who had contracted a communicable disease were nursed in single rooms, there was clear signage to indicate the risk of infection and the need to wear appropriate personal protective equipment.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using personal protective equipment such as gloves, masks and aprons. There were sufficient amounts of personal protective equipment on each medical ward.

Visiting had been restricted at the time of our inspection, to reduce the risk of COVID-19 infection for patients. However, those who needed extra support due to complex needs such as dementia or patients who were on end of life care could be visited by friends and family.

We observed domestic staff deep cleaning side rooms which had previously had a patient with a communicable disease, in preparation for a patient to be admitted to that room later that day.

Staff disposed of clinical waste appropriately, areas where clinical waste was stored was visibly clean and well organised.

There were stations for donning and doffing of PPE, bins were not overflowing and were clean. Sharps bins were dated, not overfilled and partly closed when not in use.

The wards had disposable curtains however these were not always dated.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Staff cleaned equipment after patient contact, however they did not always label equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Medical wards were a mix of bays, which were gender specific and side rooms. On one ward the ward manager told us that a risk for the ward was non-visible beds from the nurses' station. This risk had been placed on the ward's risk register and the ward had implemented bay nursing to reduce this risk. If there was a patient who was at high risk of falls and they were in a side room or non-visible bay then one to one care would be provided.

Medical wards had suitable numbers of equipment to help with mobilising patients such as hoists and wheelchairs. This equipment was well maintained and had been serviced in the past 12 months.

On both the complex coronary care unit (CCU) and the acute stroke unit (ASU) there was specialist monitoring equipment which allowed for monitoring information to be displayed on the nurse's station for remote monitoring.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were checked daily. We reviewed these checklists and each had been completed appropriately. The resuscitation trolleys were correctly stocked, oxygen cylinders were full, suction machines and defibrillators were in working order.

We reviewed a sample of equipment such as defibrillators, suction machine and blood pressure monitors which had stickers to indicate that they had maintenance checks in the last 12 months.

Patients could reach call bells from their beds and call bells in the toilets and wash areas which were in suitable places for a patient to reach if they needed assistance. During our inspection we observed staff attending to patients promptly when a call bell had sounded.

The hospital had created a new therapy room on the same level as the stroke ward, to allow for physiotherapy rehabilitation and occupational therapy assessments.

The service had suitable facilities to meet the needs of patients' families. On the Coniston suite there was facilities for patients' families to stay over.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Nursing staff told us they had annual sepsis training day, which was face to face and involved working on a dummy simulation and staff were assessed on their actions. Staff received training in National Early Warning Scores (NEWS2) and were able to describe the process for escalation of a deteriorating patient.

Staff described how they would respond to a deteriorating patient. They would continue to monitor the patient and escalate to a doctor and the nurse in charge.

Patients who had presented in A&E with sepsis would begin the sepsis pathway there, before they came onto a medical ward. Medical wards had posters which alerted staff of the sepsis screening tool and the urgency for antibiotics of patients who had shown red flags. Staff were able to describe the signs of a patient who had developed sepsis whilst an inpatient and understood the importance of escalation and monitoring.

Staff we spoke with knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included falls, pressure ulcers and Waterlow.

Staff carried out intentional rounding observations every four hours, however nursing staff told us that this was assessed on an individual basis and that patients could be reviewed more frequently when required. This meant that any changes to a patient's medical condition could be identified promptly and escalated appropriately. Patient records we reviewed confirmed this.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff told us they would liaise with the mental health team to review patients who were at risk of suicide or self-harm. The team would review the patient within 24 hours and would formulate a plan going forward, which would take into account future care and how discharge would be managed. Staff also had scenario-based ligature awareness training so that they could support patients who were at risk of self-harm.

There were "call don't fall" posters on medical wards which encouraged patients who were at risk of falling to call for assistance. There was also falls prevention posters for staff with detailed guidance to follow with a post falls checklist.

The trust used the National Institute of Health Stroke Scale (NIHSS) to access stroke patients. This tool allows staff to assess stroke related neurologic deficit. All staff who were required to be trained in NIHSS for monitoring and care for acute stroke patients were compliant with this training.

Consultants told us there were two formal handovers each day. If a patient deteriorated and needed to be transferred to the intensive care unit this was escalated and coordinated quickly.

Staff completed and arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Medical care (including older people's care)

Shift changes and handovers included all necessary key information to keep patients safe. We observed at safety huddles and handovers where key information such as falls, and safeguarding had been passed between teams.

On the stroke ward there was a dedicated unit for caring for newly admitted stroke patients which was known as the acute stoke unit (ASU). This unit had an allocated nurse who stayed on the unit to provide enhanced care to newly admitted stroke patients. Stroke patients were monitored on the ASU for the first 72 hours of their inpatient stay. If a nurse needed to leave the ASU, cover was organised so that there was always a registered nurse on the unit.

There was a system for highlighting patients who had complex needs, for patients living with dementia a butterfly symbol was added to their notes.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. At the entrance to each ward there was a safety thermometer which displayed the expected and actual number of staff on the ward for that day, during our inspection each ward we visited had the correct amount of staff to meet expected target.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. A recognised electronic rostering system was used to determine the number of staff needed to match the acuity of patients.

The results from the nurse staff rosters were correlated to undertake a review of nurse staffing within the trust. Data from the safer nursing care tool had culminated in a paper which was going to the trust board regarding staffing shortages. The staffing review was a trust care group piece of work and the plan was for a twice-yearly safer nursing care tool review, to support safer staffing moving forward which would be in line with national staffing requirements.

Ward managers told us they did not regularly use agency staff but used bank staff to support when staffing was low. Ward managers would highlight bank shifts which were available to staff on that particular ward through staff notice boards and staff group emails to ensure continuity of care for patients.

Ward managers told us that if staffing on the ward was low they would support and that advanced nurse practitioners would also help on the wards.

We observed newly qualified nurses working supernumerary which allowed them to observe and work with a registered nurse throughout their shift to learn and develop. Newly qualified nurses told us they had a 12-week induction and had been assigned a nurse preceptor who they could raise any concerns or questions with.

The trust ran an international nurse recruitment programme. We spoke to an international nurse who told us they were now registered with the Nursing and Midwifery Council (NMC). For international nurses there was a practice education facilitator to assist with training and once international recruits had achieved their nursing competencies, they worked supernumerary for four weeks.

Nursing staff told us that staffing had improved over the previous months during the staffing review however there were still some vacancies in nurse staffing.

For patients with complex needs such as those on a DoLS who may need one to one care, this would result in a member of staff coming off the ward floor, this position would then be filled by a bank staff.

Nursing staff told us that if they had any concerns due to the lack of staffing they would raise this with their ward managers. Ward managers confirmed this and told us they would escalate concerns to matrons and clinical leads.

We observed an evening handover, the day ward manager handed over to the night team. The night nurse in charge allocated patients and took handover for all patients, the night nurse in charge discussed staffing and asked staff if they felt there was the correct number of staff and skill mix on the ward.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep patients safe. There was a consultant on call during evenings and weekends. At weekends there was an increased number of consultants available usually three consultants each day across all medical wards. The consultant on call at weekends and evening was supported by a registrar and two junior doctors

In September 2021 the medical staffing skill mix showed the proportion of consultant staff to be lower than the England average and the proportion of junior doctors to be higher than the England average. Consultant staff made up 38% of medical staff which was lower than the national average of 45%, middle grade and registrars was 36% which was the same as the national average and junior doctors made up 26% which was higher than the national average of 20%.

The trust had 49.2 whole time equivalent (WTE) consultants in post, which had reduced from 51.2 in September 2021.

Senior leaders told us it was difficult to recruit at consultant level in certain specialities and that they had relied on locum doctors to supplement staffing. The trust did perform better for junior doctor staffing levels however senior leaders commented that sickness and absence due to COVID-19 had a negative impact to staffing in the previous three months.

The hospital's overall junior doctor cover had been increased to ensure that suitable numbers of staff were on duty or on call. Middle grade and junior medical staffing had increased since September 2021.

The hospital used a telemedicine service for out of hours care for stroke patients. This allowed for stroke patients to be assessed by a stroke consultant via a videoconference technology out of hours when stroke consultants were not on site to allow for timely diagnosis and intervention.

Managers could access agency and locum staff when there was staffing shortages due to sickness or annual leave. The trust employed an absence co-ordinator who staff confirmed was helpful in highlighting positions which needed to be filled.

The stroke unit had an expected staffing of four WTE consultants however one of the posts had not been filled, the stroke ward had recently employed a locum consultant to assist with the care of older patients on the ward to reduce the workload for the three stroke consultants.

Medical care (including older people's care)

Medical staffing was reviewed daily through a medical staffing call at both hospital sites, this included the medical coordinator who managed the rotas. Rotas were reviewed and juniors were reallocated when required. The trust was trying to reduce reliance to agency and locum but this was reported as difficult due to the nationwide shortage of doctors.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records consisted of both electronic and paper notes. Paper notes such as do not attempt cardiopulmonary resuscitation (DNACPR) were kept in yellow folders so that staff could find them quickly if needed. Paper notes were also scanned and uploaded to the electronic system.

Training for the electronic patient record system was included for nursing staff during their induction. However, some nursing staff we spoke with highlighted that the electronic record system was sometimes difficult to use because there were multiple places where entries could be saved to. This meant that information was sometimes difficult to find.

The electronic system contained relevant risk assessments bundles such as falls, nutrition pressure ulcers and sepsis. We reviewed 10 patient notes which all had been completed appropriately, risk assessments had been carried out when patients had been admitted to the wards and DNACPRs and DoLS had been completed correctly if needed.

Records were stored securely in lockable drawers. We observed staff checking cabinets were locked and secure when they had finished reviewing patient notes.

Electronic record systems were accessed through computers throughout the ward. These computers could be assessed by personal identification cards and were username and password protected. Staff ensured that computers were locked when they were not attended, and we observed staff reminding their colleagues to not leave identification cards in the computers.

Each patient admitted onto medical wards had admission documentation completed, this was audited regularly by matrons for compliance. Matron checks included whether staff were aware of how to raise a safeguarding concern, if all patients' safeguarding concerns had been reported, if patients had a DoLS in place was the correct documentation including authorisation present, if patients had a DNACPR in place was it appropriate and had the correct form been completed. Compliance for this audit for the last three months was 92%.

Medicines

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

Staff did not always follow systems and processes to prescribe and administer medicines safely. Capacity in the pharmacy team for medicines reconciliation and clinical review was limited. Plans had been agreed to expand this team to provide increased support, with an initial focus on medicines reconciliation (admission checks) and antimicrobial stewardship.

The trust had access to the local integrated care record system to enable patients' medicines to be checked with their GP's list when they came into hospital. However, as seen at our previous inspection, medicines were not always reconciled in a timely way on admission to hospital. At Furness General Hospital medicine reconciliation was 54.8% (February 2022) against a trust target of 80% in 24 hours.

A new discharge checklist had been implemented to help ensure that patients' medicines changes and side effects were discussed with them before going home. However, only 22% (February 2022) of take-home medicines were ready in one hour against a trust target for 80%. The trust did not yet have a process for referring patients who would benefit from support with their medicines to their community pharmacist on discharge. However, they were working with the ICS (Healthier Lancashire and South Cumbria Integrated Care System) to implement this service.

The pharmacy team had clear processes in place to focus their activity to areas that would have the most impact. They also contacted the medical wards daily to identify any patient who may be going home, in order that they could start the discharge medicine checks. However, most medical wards received only a limited clinical pharmacy service, which was further reduced at weekends. Wards commented that they only saw the pharmacists 'virtually 'and that 'physical presence would be better'. Only the coronary care and high dependency unit saw a pharmacist 'most days'.

We found that the trust antimicrobial prescribing guidelines were not consistently followed. The indication was not always recorded, and prescribing reviews were not always clearly documented.

We saw one example where medicines for violence and aggression had been prescribed outside of current guidance [NICE NG10] and drew this to the attention of ward staff in order that this could be reviewed. However, the trust was reviewing their policy for the management of violence and aggression to include clearer guidance about the use of medicines, when needed.

A business case had been recently approved to expand the pharmacy workforce to support medicines reconciliation and antimicrobial stewardship.

The trust was implementing electronic monitoring for medicine fridge and clinic room temperatures to help ensure medicine were stored correctly. We saw that appropriate action was taken should either the clinic room or refrigerator temperatures be out of range.

Monthly reported incidents including for medicines were discussed and shared at ward meetings.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff could describe the protocol for incident reporting and also gave examples when they had reported incidents such as pressure sores, Deprivation of Liberty Safeguards (DoLS) and falls. They told us it was mainly nurses who would report these.

Ward managers had oversight of the incidents which had occurred on their ward. Incidents were reported through an electronic system, the ward manager reviewed the incident, investigated and escalated accordingly. Learning and improvements were shared through staff meetings and safety huddles.

Once an incident investigation had been completed, the ward manager would also give feedback to the incident reporter before closing the incident.

Medical care (including older people's care)

Staff on ward 7 told us that the morning and evening huddles were used as an opportunity for lessons learnt to be shared. Staff had developed a way of sharing lessons learnt by adapting the lesson into a story called 'Bobs story'. Instead of describing the incident alone they described it as happening to a fictional character called 'Bob'. The clinical lead told us that this method removes blame and focuses more on lessons.

The ward manger on ward 9 told us that they encouraged staff to report incidents and do a reflective account to learn from it, they had patient safety meetings and lessons learnt meetings every week.

Not all staff understood duty of candour, however when it was explained to them staff gave examples of when they had been open and transparent with patients such as a medication error, staff told us they would inform the patient and explain to them what had gone wrong and apologise.

Staff graded incidents in relation to the severity of harm, a ward manager had shown us duty of candour letters that had been sent out to patients that had contracted COVID-19 in hospital which they classed as moderate harm. Duty of candour letters were also sent for any falls or fractures and an opportunity was offered for staff to speak with patients and family members.

The medical care group had no reported never events in the past 12 months, a never event is serious incident that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. There had been 10 serious incidents reported on medical wards over the past 12 months at Furness General Hospital. A review of these incidents highlighted no themes or trends.

Between December 2021 and March 2022 there had been 148 incidents relating to slips, trips or falls recorded on medical wards. During the same time period the number of incidents relating to pressure sores which patients had developed while an inpatient was 38 and the number of pressure sores which had deteriorated while an inpatient was 11.

Staff could access a learning library on the trusts intranet which shared all serious incidents and the learning from them. All these serious incidents had been through the trusts serious incidents panel and the findings and improvements were fed into the harm free care initiative.

The trust reviewed daily incidents which were rated at moderate harm and above to make sure they were triaged and managed through the appropriate routes. These were reviewed at a weekly executive review group to ensure the appropriate investigations had been being carried out.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Medical care (including older people's care)

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could view policies on the trust's intranet system, policies we reviewed were in date and had a review date.

Newly admitted stroke patients were cared for and monitored appropriately the first 72 hours in the hospitals new Acute Stroke Unit (ASU). This unit had been developed following the last CQC inspection.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were able to explain what mental capacity was and how they assessed for this.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed staff discussing physical, social and emotional needs of patients during handover and the action plans which had been put in place such as referral to the mental health liaison or support from occupational therapy.

On the stroke unit, staff told us that improvements had been made when assessing newly admitted patients. Each patient had a swallowing and dysphagia screening assessment on admission by the speech and language team (SALT). Stroke nurses told us they had been trained by the SALT team to carry out swallowing assessments so that patients could be assessed in a timely manner if a member of the SALT team was not available.

Nurses on the stroke ward had training in National Institute of Health Stroke Score (NIHSS). This assessment tool is used to evaluate and document neurological status in acute stroke patients.

Stoke patients sometimes undergo a treatment known as thrombolysis. This treatment uses a medication to break down blood clots to improve blood flow and prevent damage to healthy tissue and organs. Nurses in the stroke unit confirmed that, for patients who had undergone thrombolysis, that insertion of nasogastric tubes or catheters would not be carried out in the first 24 hours following the procedure due to the increased risk of bleeding. This was in line with national guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff used a trust developed tool, to regularly check throughout the day if patients were in pain, needed water and were comfortable. Each patient had a nutrition score chart and for patients who were at risk of losing weight staff completed a food chart.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Medical care (including older people's care)

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition University Screen Tool (MUST) for each patient, this screening tool is used to identify patients who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan. If a patient scored high on the assessment, then staff would request input from the dietician team.

Specialist support, from staff such as dietitians and speech and language therapists, was available for patients who needed it. Patients had access to a dietician assessment and were put on a specific diet if needed. Staff adapted thickness levels of food where needed and displayed it on the patients' bed board.

Patients who required assistance with food were discussed in handover and this information was displayed in the patients' notes. We spoke with patients with complex needs such as those living with cerebral palsy who needed help drinking. They told us that they always received support when they needed a drink and were supported when eating.

Patients had choice of food they were given and there were optional menus for patients who had specific dietetic or religious requirements. The ward we visited had protected mealtimes, which allowed nurses and clinical support workers to be available to support patients who may need it.

Pain relief

Staff 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 assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain was assessed during a process known as intentional rounding, this is structured process whereby nurses carry out regular checks of individual patients to address issues of positioning, pain and personal needs. For patients who were experiencing high levels of pain they would be reviewed more often if needed.

Patients received pain relief soon after requesting it. Patients we spoke with told us they received pain relief in a timely manner and were reviewed following this to check if the pain relief had been effective.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service participated in relevant national clinical audits. We interviewed senior leaders who said the medicines care group continued to submit data to the Sentinel Stroke and National Audit Programme (SSNAP), national hip fracture, lung cancer, chronic obstructive pulmonary disease and bowel cancer audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

Medical care (including older people's care)

The trust submitted data to the National Audit of Bowel Cancer 2021, where results were in line with national and regional data. 100% of patients were seen by a clinical nurse specialist against a national average of 86%. The hospitals 30-day unplanned readmission rate was in line with that of the region. Both the hospitals 90 day and two-year mortality rates were also in line with hospitals within the ICS.

From the trust's most recent sepsis screening and treatment of inpatients audit data provided, it was shown that, for patients who had red flagged for sepsis, 93.5% had received antibiotics within one hour of being diagnosed, 93% had a senior review, 100% had oxygen delivered when required and 90% of patients received intravenous fluids when required.

The most recent SSNAP data for Furness General Hospital showed they had received grade C between October 2021 and December 2021. SSNAP data is scored from a range of A (Best) to E (Worst). The SSNAP audit looks at key performance indicators such as the time it takes for a patient to be scanned following a stroke, the time taken to be admitted to a stroke unit, the percentage of patients given thrombolysis who were eligible and the time it took, the percentage of patients assessed by a stroke consultant with 24 hours and the percentage of patients who had a swallow screening test within four hours.

The SSNAP data from July to September 2021 (Quarter 2) indicated that Furness General Hospital was able to achieve a timely admission to the stroke unit for the majority of patients, 84.1% of patients where admitted to the stroke unit within four hours this was an improvement of 22.3% from the previous quarter.

From August 2020 to July 2021, patients at Furness General Hospital had an expected risk of readmission for both elective and non-elective admissions similar to the England average.

From September 2020 to August 2021, the average length of stay for medical elective patients at Furness General Hospital was 5.1 days, which was lower than the England average of 6.4 days. For medical non-elective patients, the average length of stay was 6.8 days, which was higher than England average of 5.8 days.

The service had a higher than expected risk of readmission for elective care than the England average. From August 2020 to July 2021, all patients at Furness General Hospital had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England average.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Medical wards carried out audits on the completion of NEWs documentation completion. Over the previous three months medical wards had achieved and average of 97% compliance.

Managers used information from the audits to improve care and treatment. Medical wards had audited patients having multi-disciplinary assessment within 14 hours of admission which is known as the Keogh standard, medical wards had achieved a compliance of 93.8% for the three months prior to the inspection.

Managers and staff investigated when they were outliers in any audits and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits. Managers told us that information gained from audits would be shared through staff meeting and group emails.

Medical care (including older people's care)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Nursing staff were provided with an induction workbook, which outlined their induction processes and what they would be expected to achieve. The induction process highlighted to the member of staff who their preceptor would be and also outlined that they would have regular checks ins throughout their induction to check the progress they had made.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke to said that they had received a constructive appraisal in the past 12 months. From the data provided 85.9% of staff on medical wards had received an appraisal in the last 12 months, against a trust target of 95%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

The clinical educators supported the learning and development needs of staff. The hospital had a clinical education team in place who had assisted in the development in both newly qualified and international nursing recruits.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. If staff members were not able to attend a team meeting the meeting minutes were shared through group email, to allow staff the opportunity to keep up to date with any changes or learning which had been highlighted.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. For nurses working on the stroke unit, staff had completed training in the Fundamentals of Acute Care for the Treatment After Stroke (FACTS) the service's compliance for training was 70%.

The service had 100% compliance for training in the in NIHSS assessment tool which is needed for staff who were involved in the monitoring and care of acute stroke patients.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers were able to tell us about times when they needed to highlight to staff poor performance in regards to not filling out patient notes correctly and a timely manner, the importance of this was highlighted to the staff member to improve care in the future.

A consultant we spoke with told us that junior staff were assigned a clinical supervisor and an education supervisor. They felt they had access to specialised training and were supported when they highlighted training which would improve the care they gave.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. A consultant we spoke to told us they had multi-disciplinary team (MDT) meetings daily Monday to Friday with junior doctors, consultants, nurse in charge, allied health professionals and discharge co-ordinators.

The clinical lead on ward 7 told us they had a system called 'we see' that cascades clinical governance meetings down to all staff levels and they had daily ward huddles followed by governance huddles both morning and evening.

The stroke unit had a large multidisciplinary team which consisted of doctors, nurses, SALT, dieticians and allied health professional such as physiotherapists and occupational therapists.

Staff we spoke with commented on the positive culture throughout the medical wards, they said they felt there was good team working across all clinical staff.

Patients had their care pathway reviewed by relevant consultants. We observed ward rounds while on inspection there was input from medical staff, nurses and allied health professionals.

Staff referred patients for mental health assessments when they showed signs of mental ill health and depression. Staff knew how to contact the mental health team and told us the team would review a patient within 24 hours of a referral being made.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Speech and language therapy teams were available five days a week, for stroke patients who had been admitted at the weekend the SALT team had trained stroke nurses to carry out swallowing and dysphagia assessments so that stroke patients could get assessments in a timely manner.

There was a consultant on call 24 hours a day, they consultant on call worked between 8am and 8pm seven days a week, care was then handed over to a consultant who covered the night shift seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The stroke unit had three stroke consultants who provided medical cover Monday to Friday. Consultants were on call at weekends and had a rota to attend on Saturday and Sunday to assess newly admitted stroke patients. Stroke consultants were supported by two advanced nurse practitioners and a nurse consultant who worked Monday to Friday, but they had also developed a rota to cover weekend working to assist with newly admitted stroke patients.

Therapy services such as physiotherapy and occupational therapy were provided Monday to Friday. There was some capacity for therapy services to be provided at weekends but due to vacancies in the workforce at the time of the inspection this had reduced.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. There were leaflets available which offered advice on health promotion.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff were assessed for smoking cessation and alcohol dependency as part of their assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Records we reviewed showed that staff had gained consent from patients including patients who lacked capacity to provide informed consent to care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff told us if they were unsure about a decision regards consent, mental capacity assessment (MCA) or DoLS that they were able to access the relevant policy on the trust's intranet. Both the MCA and DoLS policy outlined clearly staff responsibilities when it came to making decisions, performing capacity assessments and gaining consent.

Staff made sure patients consented to treatment based on all the information available. We observed staff asking for patients' consent before carrying out procedures such as taking blood.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act (2005).

When a patient had a do not attempt cardiopulmonary resuscitation (DNACPR) in place this was placed within a yellow folder that it was clearly visible to staff and could be found easily in an emergency. During handover we observed staff confirming the patients who had a DNACPR in place on the ward.

We reviewed six DNACPR forms during our inspection, the forms were all completed correctly. The forms included information on a reason why the DNACPR had been put in place, if a discussion had been had with the patient and where the patient lacked capacity a discussion was documented with a family member.

The trust policy outlined the standards for a DNACPR being placed. These included that a 100% of patients who had a DNACPR must have a form completed, that 100% of the patients must had the decision recorded in their notes and that 100% of patients must have an alert on the electronic patient record.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff completed DoLS appropriately and once a DoLS had been initiated a referral would be made to the safeguarding team to make them aware of that patient.

Staff received training on MCA and DoLS, compliance data provided by the trust showed medical wards overall had a compliance of 83.1%.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

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. Staff ensured curtains and doors were closed during consultations to ensure privacy for patients. We observed staff interacting with patients in a respectful and positive way. We observed staff explaining to staff when changes had been made to a patient's care plan and asking if they had any questions.

Patients said staff treated them well and with kindness. Patients told us that communication was good and that staff knew a lot of information about their care and treatment which was shared with them.

We observed doctors carrying out a ward rounds on the stroke unit. The doctor carrying out the reviews introduced themselves and asked how the patient was feeling and explained what they were going to do.

Staff followed policy to keep patient care and treatment confidential. We did not witness any notes being left unattended and staff made a conscious effort to ensure records were locked away when not in use.

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.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There were posters on the ward that directed patients to the multi faith chaplaincy centre and when services were held.

The trust provided data from the friends and family test. For January and February 2022, the service had received a positive score of 91.5% with and average response of 15% of those who had received care on a medical ward.

Medical care (including older people's care)

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. We observed staff caring for patients with complex needs who needed assistance with eating and personal care activities.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a nurse assisting a patient living with dementia who had become confused on the ward, the nurse walked with the patient explaining to them where they were and why they were in hospital and then escorted them back to their bed and asked them if there was anything they needed. This interaction was carried out in a positive and caring manner.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A ward manager we spoke with told us that staff were kind and compassionate but would like more time to talk to patients and more time for families when delivering bad news.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

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.

The trust supported John's campaign, which supports the rights of people living with dementia to have a carer to advocate for them and be with them whenever they most need it.

The service had a family liaison service to support communication between patients' families and staff. Families could ask the family liaison service questions; the team would then feedback as soon as they had the correct information. The family liaison team would update families on treatment plans, therapy goals and discuss medical progress.

Medical wards used an electronic tablet which had a video calling application that family members could download to their phone, the patient's family members would then book a time to speak to their relative.

Ward rounds with doctors and patients took place daily with treatment plan and communication shared. Due to COVD-19 visiting restrictions that had been put in place, no family members were allowed to visit the wards. However, staff would update family members on the phone, for example patient test results.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff spoke about a patient living with dementia who could not speak, staff told us they assisted them to write down what they wanted and took time to support them.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff had told us that if breaches occurred due to the need to move patients when there had been an outbreak of a communicable disease such as COVID-19, then this would be incident reported.

Facilities and premises were appropriate for the services being delivered. The service had developed a new acute stroke unit which was used to care for, and closely monitor, up to four newly admitted stroke patients for the first 72 hours of their care.

There were challenges for the provision of care in the community across the region, which impacted on staff ability to discharge patients. Each ward we visited had a discharge coordinator whose role was to plan discharges and liaise with other bodies to ensure support for patients and ensure safe discharge.

The service had recently developed a same day emergency care (SDEC) unit to reduce pressures in medical wards by reviewing patients in a timely manner and therefore reducing admissions to the hospital.

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. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had passports for patients who had complex needs such as learning disability or autism. These forms highlighted to staff that they must never assume the patient lack capacity and that if it was documented a patient did lack capacity then a formal best interest decision must be made and documented in the patient's notes.

The complex needs passport also highlighted to staff reasonable adjustments that should be made and highlighted to staff if patients had any impairments and how to best support them.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia.

Wards were designed to meet the needs of patients living with dementia. The service had dementia friendly TV which played old movies, it could be moved across the wards and staff commented that patients really enjoyed using it.

Medical care (including older people's care)

The dementia matron for the service had an enhanced care policy to support care for patients who presented with confusion and who required risk assessments of behaviours to ensure safe supervision and positive engagement.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

For patients using wheelchairs the service's entrances and exits had automatic doors, there was lifts to all medical areas and toilets and wash areas were wheelchair accessible.

We visited the discharge lounge where patients waited for transport after they had been discharged. Patients were offered hot and cold drinks and if there were long delays waiting for their transport then food was offered.

Staff understood and applied the policy on meeting the information and communication needs of patients living with a disability or sensory loss. We observed a patient living with cerebral palsy who had their call bell positioned by her hands in a way that they could use the bell easily when needed. They told us that all their needs had been met, they were supported with eating, drinking, being washed and dressed and were happy with the level of care and treatment.

The Maple Suite on ward 9 was for patients at the end of life. Family members could sleep and have access to living facilities such as a kitchen and dining area. Staff said patients and their families had given good feedback and this was accessible to any patient from across whole hospital. Two patients had been married in the suite by the hospital chaplaincy. Staff decorated the maple suite when a wedding was taking place.

The service had a dementia nurse who carried out in-depth assessments and a palliative care team who gave guidance and support with end of life care, which consultants believed helped guide staff in carrying out that patient's care.

The service had information leaflets available in languages relative to the local community.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients made a choice of food from daily menus which they were presented with each morning and for patients living with dementia had a specially adapted menu for example finger food which was easier to eat.

The hospital had a butterfly scheme. An outline of a butterfly was behind the bed for patients who were confused and a coloured butterfly for patients living with dementia.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff on all units told us they used a translator machine from the emergency department to communicate with Polish and Chinese speaking patients, to ask them questions such as 'are you in pain?' or 'how are you feeling?'

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

There were 33 patients waiting for treatment over 104 weeks, compared nationally for patients waiting over 104 weeks, the trust was in the bottom 25%.

Medical care (including older people's care)

For cancer patients only 57.5% of patients were treated within 62 days of referral from their GP, this was below the national target of 85%, the trusts performance was similar to the England average.

In January 2022, 79.1% of patients of both admittance and non-admittance were treated within 18 weeks against a national target of 92%, the trust was performing better that the national average of 72.7%.

For admitted patients only 50% of patients were treated within 18 weeks against a national average of 66%, the trust was not meeting the national target of 92 %.

For non-admittance 84% of patients were treated within 18 weeks against a national target of 92%, the trust was performing better than a national average of 74%.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service had an acute medical unit which had an average stay over the past three months of 1.5 days.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The service moved patients only when there was a clear medical reason or in their best interest. Staff needed to move patients as there had been COVID-19 outbreaks and patients who had tested negative were moved to areas which had no cases to reduce their risk of contracting the virus.

Staff said they tried to keep moving patients at night to a minimum however this was sometimes needed due to lack of capacity, they told us if a patient was moved at night. They would incident report this. There had been 48 bed moves after 10pm and before 6am in February 2022 this had improved from 97 in January and 83 in December 2021.

There was also a complex discharge team who worked seven days a week. Discharge planning was commenced on admission and staff discussed planned discharge dates during handovers. This was documented in the patient notes.

Managers and staff worked to make sure patients did not stay longer than they needed to. At the time of the inspection there were 52 patients at the hospital who did not meet the criteria to reside.

Managers monitored that patient moves between wards were kept to a minimum. Managers would review the number of incidents of bed moves and would escalate concerns to a matron if they felt the practice was unsafe.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge coordinators worked with both physiotherapy and occupational therapy to decide what assistance patients may need in the community. Occupational therapists attended discharges with patients to assess their homes to ensure the environment was safe and suitable.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them.

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.

Medical care (including older people's care)

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. The service had patient liaison service (PALS) and displayed information to direct patients how to make a complaint if they needed to.

The service had a patient experience group. We reviewed the meeting minutes of this group for February 2022, in the meeting they discussed complaints of which there had been seven formal complaints in the previous month and 26 registered compliments. The group discussed lessons learnt from complaints such as discharge processes, supervision of bays and the importance of thorough examinations.

The medical care group had alerted members of the patient experience group to increases in demand and patient flow highlighting that this may have an effect on patient experience.

Wards displayed complaints and compliments on display boards at entrances to each ward. The boards had a section for “you said, we did” where staff had shown how they had actioned suggestions from patients.

Staff on AMU told us they gave patients leaflets to take home and post back with feedback. The unit was then scored, and this was displayed on the ward. We saw evidence of this feedback being displayed in this way.

The ward manager on ward 9 told us that they stopped using the method above and instead trialled using an IPAD followed by text message to give feedback but they did not receive as many responses now compared with the old system with the paper cards. Ward managers described a lot of positive feedback from patients who had responded.

Staff understood the policy on complaints and knew how to handle them. Staff told us they would try to resolve complaints at the point of care, however if it could not be resolved they would give the patient and family their ward manager’s details and PALS information.

Managers investigated complaints and identified themes. Ward managers told us that they dealt with complaints or concerns and would speak with patients and their families directly. For formal complaints they investigated these and completed a report which was sent back to the patient relations team. Following this process and interactions with the patient and their families, lessons learnt would then be shared with staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints and concerns were shared at team meeting and daily huddles.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave an example of lessons learnt from a complaint. This was a patient who was transferred home by ambulance without their required oxygen. This had led to a new tick box transport sheet being developed and used. This sheet prompted staff to action and communicate oxygen needs to the transporting service.

Medical care (including older people's care)

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical core service was part of the medicine care group and was covered by a triumvirate which consisted of a clinical director, an associate director of operations and an associate director of nursing. The triumvirate were supported by business partners for governance. The team held weekly senior operations meetings and attended weekly trust management meetings.

Wards were managed by ward managers who were supported by matrons. Staff commented that ward managers and matrons were visible and supportive.

On the wards we visited, ward managers had an open-door policy so that staff could speak to them and raise any concerns at any point. Ward managers were visible on the wards and supported staff when needed.

The division had identified gaps in medical staffing and were looking at ways to retain and increase staffing. They commented that it had become increasingly difficult to recruit to senior medical posts. They recognised the importance of exit interviews as rich information for retaining staff in the future. The trust did not accept British Medical Association (BMA) guidance on retire and return of medical doctors.

Staff commented that they felt supported with opportunities for role development and career progression. Ward managers had started band 6 nurse development days to allow for training in skills such as people management and e-roster completion to help staff develop and take up managerial posts in the future. Nurse staff at the hospital could apply for education funding which could be used over three years for any training or courses which would improve their clinical skills and career development.

The medicine care group had focused on international recruitment and was successful in supporting international recruits to practice in the UK. The service had carried out a process of preliminary recruitment for student nurses so that they were able to retain staff they had trained. Student nurses were recruited 12 months prior to their graduation.

Senior leaders had highlighted that a number of senior nurses were retiring in the coming year and were putting processes in place to develop staff to take up these positions.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Medical care (including older people's care)

The trust vision was “We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners.”

The trust had a clinical strategy dated from 2019 to 2024, this strategy focused on providing safe and sustainable services to its patients, ensuring its workforce was engaged and developing workforce models to meet service needs and supported work in the wider integrated care system.

The medicines care group aligned with the trust strategy. The care group’s own strategy was to develop the finance, performance and transformation of the service while having a focus on quality and safety and placing importance on colleague health and wellbeing. The medicines care group plan for 2022/23 highlighted key risks such as recruitment and retention, maintaining staff health and wellbeing and delivery of key performance standards particularly for urgent care and cancer pathways.

Not all staff we spoke with were aware of the vision and strategy for the medicine care group or the trust.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

When we spoke with senior leaders, they commented on how proud they were of the staff and the work they had done throughout the pandemic. They highlighted key areas of improvement such as the stroke service which had been brought into focus following the CQCs previous inspection, they commented on a fantastic team effort of clinicians and managers to force through significant change and improvement.

Senior leaders commented on the high levels of resilience shown by staff, they believed staff had risen to the challenges that had been presented over the last 12 months. All staff were seen to be keen to get involved in improvement of the service. There had been occupational therapy involvement to aid staff wellbeing and a wellbeing program had been set up to help with bespoke support for staff from wellbeing ambassadors.

On the wards we inspected, we observed good teamwork and high morale. Staff had commented that teams had pulled together to combat the pandemic and that there were good relationships between all work groups such as medical, nursing and allied health professionals.

Staff told us they felt there was an open culture and staff felt safe to raise concerns if they had any.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medicine core group held monthly governance meetings where they reviewed serious incidents, mandatory training compliance and risks. We reviewed the minutes of a recent medical care group governance and assurance meeting. These included key discussions around workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

Medical care (including older people's care)

The medicine core group held weekly medical lead meetings which involved senior clinicians and nurses. Key information from these meetings was cascaded through a board to ward framework called ‘we see’ which cascades clinical governance meetings down to all staff levels and they had daily ward huddles followed by governance huddles both morning and evening.

Staff told us that minutes from clinical governance meetings are available on the intranet if they wanted to read them.

The trust reviewed daily incidents which were rated at moderate and above to make sure they are triaged and managed through the appropriate routes. These were reviewed at a weekly executive review group to ensure the appropriate investigations had been carried out.

The service recognised that falls and pressure ulcers made up a high proportion of hospital incidents. They had recently created a harm free care group which reviewed these incidents and looked at ways to reduce these incidents happening in the future.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The medicines care group had a risk register which was reviewed regularly. Senior leaders told us the service’s top three risks were staffing, patient flow due to the lack of provision in the community and the need for the service to have the correct finances.

Senior leaders commented that in terms of medical staffing the service struggled to recruit to consultant level for certain specialities.

The service had implemented a hospital at home team which had helped people with care in their own home. This was implemented to try and increase the number of carers in the community to improve discharge rates for patients who were medically fit to be discharged but who did not have the care in the community they needed. Over winter the service had utilised agency staff to support the hospital at home team with a focus on discharge from hospital.

Each medical ward had a designated person to perform mortality reviews. The clinical lead on ward 7 told us that ward managers did not review their own ward. This was done by someone from a different ward and they in turn reviewed their ward. Any issues found would be raised as a clinical incident.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff received training on information governance as part of their mandatory training, all staff on medical wards had completed the training. Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

The service had carried out an audit to assess compliance with the safe and secure storage of patient records of the medicines care group. The audit highlighted overall good practice and attitude towards patient confidentially. Recommendations from the audit included repairs to existing lockable storage, which was broken, acquisition of new lockable storage and a review and end to the practice of storing patients records in plastic wallets.

The information governance policy was also updated in response to the audit findings.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The medical care group triumvirate did regular walkarounds to make sure that they were visible to staff. Senior leaders also carried out weekly walk arounds and engaged with staff and patients. They asked both for experiences and what staff were proud of. The service had a patient experience group whose role it was to support patient feedback.

The trust worked with the ICS to support the COVID-19 recovery plan. This was an integrated systemwide plan to support the recovery of services provided by health and social care providers after the pandemic.

Leaflets about the friends and family test, and the patient advice and liaison service (PALS) were available on all wards. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards, and letters displayed at the entrances to wards.

The medicine care group had introduced wellbeing ambassadors to support staff and their wellbeing through either one to one conversation or through working with groups using facilitation skills in narrative action learning. The wellbeing ambassadors were trained in facilitating narrative action learning to support staff to move through group challenges, complex team dynamics and resolve conflict.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Senior leaders spoke about how the service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

There had been improvements made within the stoke pathway which had been highlighted in an improvement in the services SSNAP score for the previous quarter.

The service had recently created a nurse consultant lead for stroke to assist the consultant team and train staff in advanced stroke care.

Medical care (including older people's care)

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Furness General Hospital

- The trust must ensure continued development and investment in pharmacy resources to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (2) (g))
- The trust must ensure that antimicrobial prescribing guidelines are consistently followed. (Regulation 12 (2) (g))

Action the trust SHOULD take to improve:

Furness General Hospital

- The service should ensure that cleaning schedules are completed appropriately. (Regulation 12).
- The trust should ensure that their updated policy for the management of violence and aggression should include clearer guidance about the use of medicines in line with National Institute for Health and Care Excellence (NICE) guidelines. (Regulation 17)
- The trust should continue to actively seek a suitable candidate for recruitment to its stroke consultant vacancy. (Regulation 12)
- The trust should ensure it achieves its target for take-home medicines to be ready within one hour. (Regulation 12)
- The trust should review its higher than expected readmission rates for both elective and non-elective admissions.

Urgent and emergency services

Inspected but not rated

We did not rate the service at this inspection.

- The service generally had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness.
- The service planned care to meet the needs of local people. People could access the service when they needed it, however they could sometimes wait longer for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

However:

- Although staffing levels were appropriate, there was a concern that the overuse of departmental staff to fill gaps could result in staff burnout at a later stage.
- The triaging and handover of patients took place in such a manner that privacy of patients could not be guaranteed.
- The security of patient data was compromised by staff login cards left being within computer terminals, without any oversight.
- There was no system in place for department staff to access patient records, following a mental health assessment from a partnership mental health trust.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills including life support training to all staff and mostly made sure everyone completed it.

All staff received and kept up-to-date with their mandatory training.

Staff told us about the training they received during their induction and also told us that they felt they had enough training to do their job. We reviewed data which evidenced a high completion rate of Basic Life Support (BLS) training by staff, however Advanced Life Support (ALS) compliance was lower, with 14 of 18 staff members being up to date.

Urgent and emergency services

The mandatory training was of a good level and met the needs of patients and staff. We reviewed a list of mandatory training modules that covered the following topics and detailed compliance rates; Conflict resolution - 99.1%,Equality, diversity and inclusion - 100%, Infection prevention level 1 - 100%, Information governance - 100%, Manual handling (Modules A & B) - 99.1% and Resus BLS: 95.2%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us about the education facilitator and how their role was described as ensuring that training compliance was met.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Most staff received training specific for their role on how to recognise and report abuse. We reviewed safeguarding training compliance figures against the trust target of 95% and noted that one was fully met and the other two of the compliance targets were almost met.

Safeguarding Children and Adults (NHS Core Skills) Level 1 was at 100% and Safeguarding Children and Adults (NHS Core Skills) Level 2 was at 91%.

Following our last inspection, we told the trust that it must take action to improve safeguarding level three training rates for doctors and nurses. At this inspection the trust provided us with evidence that Safeguarding Children (NHS Core Skills) Level 3 compliance was at 90%, which although high was below the trust's own target of 95%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us that they understood and were aware of particular issues such as; female genital mutilation, child sexual exploitation and radicalisation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During our inspection, staff described the safeguarding alert process. Alerts were made via an electronic incident form, which then automatically referred the concern to the hospital safeguarding team, for review.

Staff told us that the safeguarding team frequently visited the department to support staff and could also be contacted readily for any advice or support.

Cleanliness, infection control and hygiene

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

At our last inspection we told the trust it must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas.

During this inspection we observed that all areas were clean and had suitable furnishings which were clean and well-maintained. The department was kept clean by staff and areas were tidied in readiness for the next patient.

The service demonstrated an improving trend for cleanliness. We reviewed information about hand hygiene training and hand hygiene audits of staff compliance. Hand hygiene audits were completed every two months, to assist with infection control.

In December 2021 the audit showed an 80% staff compliance rate, which was an improvement from September 2021 which demonstrated a 60% compliance rate.

We observed a positive correlation between higher training compliance rates and how well staff complied with hand hygiene in the audit of December 2021.

Managers audited staff compliance with infection control practices as part of a wider COVID-19 assurance framework. This helped protect patients from the spread of infection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed that cleaning records were present in appropriate areas, such as toilets. The cleaning records included the date, time and initials of the staff member whom had completed the clean.

We observed that patient privacy curtains were clean and made of suitable material, however several of cubicle curtains did not have a date on them. This meant that staff would have difficulty in identifying when a change of cubicle curtains, would be required.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff use appropriate face masks, aprons and gloves prior to interaction with patients. All staff were noted to be bare below the elbow.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed that equipment and facilities were kept clean by staff members. Staff explained to us which type of disinfectant cleaning products they would use, which was determined by the type of spillage or contamination that occurred.

Staff screened patients for signs and symptoms of COVID-19 when the attended the emergency department. These actions helped support the service to arrange for patients to be cared for in different areas of the department and reduce the risks of the spread of COVID-19.

If patients tested positive, they were cared for in isolation cubicles. There was access to point of care testing for those patients who may be presenting with COVID-19 symptoms with a turnaround time of around 10 minutes to obtain the test results.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

We observed that patients could reach call bells and staff responded in a timely manner. We heard call bells sound and observed that these did not sound longer than a few seconds at any time before they were answered.

The design of the environment was mostly spacious and open. However, we noted that within the resuscitation area of the department, some equipment was stored in a cluttered manner, which obstructed access to other equipment.

Urgent and emergency services

Ambulance patients in the initial triage area were positioned on trolleys without any privacy. Patients were also placed near an external sliding door which meant that they were subject to cold drafts. Mobile screens were available, to maintain privacy, but were not seen to be utilised. This, however, did assist with staff being able to observe patients at all times.

Staff carried out checks of specialist equipment. We reviewed three resuscitation trolleys within the department and noted they were appropriately equipped, secured and had daily check logs completed. We also observed that one resuscitation trolley included paediatric resuscitation equipment. All other relevant equipment that we observed had been checked appropriately and was within date.

The service had suitable facilities to meet the needs of patients' families. We observed that there was a specific children's waiting area available for use by families. We also noted that a number of rooms in the department were decorated or themed, so that they would be more suitable for children or patients with complex needs, for example those with learning disabilities.

We did note that at times the minor injury waiting area had no direct staff oversight after 5pm, however there was CCTV covering that area. This meant that patients may deteriorate without staff awareness.

We observed that the service had enough suitable equipment to help them to safely care for patients. During the inspection we noted that all equipment we sampled, was in date and available for staff.

We also observed a dedicated room for patients with complex mental health needs. This room was appropriately furnished and did not contain any ligature points to maintain the safety of patients.

We observed that staff mostly disposed of clinical waste safely. Sharps bins were mostly labelled and dated and below the fill level, however most were left open. We noted that safety was not consistent as one sharps bin in a sluice room was undated and had intravenous tubing sticking out of the opening.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Following our last inspection, we told the trust that it must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients.

During this inspection we found that staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.We observed that national early warning scores (NEWS2) were carried out for adults and similar charts for pulse, respiratory rate, blood pressure, temperature (CPOTTS) were carried out for children. The NEWS and CPOTTS scores were available on electronic patient records.

The NEWS and CPOTTS scores were also written on a whiteboard within the nursing area of the department along with other relevant information. For example, where tests had been ordered these were listed on the board under the relevant patient name and crossed off when they had been completed. Staff told us that they were aware of when specific NEWS or CPOTTS scores were reached, a patient's care would be escalated.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly. We observed that patients were triaged upon their attendance at the department, by qualified and experienced staff.

Health care assistants undertook preliminary tests or investigations such as bloods or heart readings, so that patients could be referred to the most appropriate service or department, in a timely manner. This also ensured that a clinician, at the time of review, had up to date and relevant information for a fuller clinical picture of the patient's presentation.

For the trust as a whole and for the most recent month available of January 2022, the average time from ambulance arrival to initial assessment, was seven minutes. This was a one-minute increase in the previous year of January 2021, where the average time from ambulance arrival to initial assessment was six minutes. We observed that a nurse was available to receive patients immediately on arrival, by ambulance to the department.

Staff knew about and dealt with any specific risk issues. Staff described to us the specific pathways in place for suspected stroke and sepsis cases. The pathways had clear stages, took account of how the patient arrived within the department and were well articulated by the staff we spoke with.

Following our last inspection, we told the trust that it must ensure that, patients with mental health concerns are seen in a timely way.

During this inspection we noted that the service had 24-hour access to mental health liaison and specialist mental health support. Staff told us that if they had concerns about a patient's mental health need, they could call on the mental health team.

However, the notes of the mental health team could not be accessed by department staff, as they were located within another NHS trust's electronic records system. We noted that there were long waits to access a mental health trust bed, for some patients.

During our inspection we observed staff handovers and noted that all key information was shared to the member of staff taking over a patient's care.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

Emergency department management told us that nurse staffing levels were an ongoing issue, however we were assured that the service had enough nursing and support staff to keep patients safe. During our inspection we noted that the department was fully staffed with eight staff nurses and nine health care assistants.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staff told us that nurse staffing levels could vary from shift to shift and could be impacted by other pressures, for example COVID-19 sickness absences.

Emergency department management told us that they adjusted staffing levels and roles within the department to respond to patient needs. For example, when staffing was identified to be an issue, then a staff member who accepted handovers from ambulance staff could be assigned to a crucial patient care area.

The service mostly had a good skill mix of nursing staff on each shift, however staff acknowledged that it could at times, be a challenge due to staff absence rates. Emergency department management attempted to mitigate this by looking to increase the training of the staff in different competencies and skills.

Urgent and emergency services

The service acknowledged vacancy rates were a challenge to fill. Staff told us that there were eight roles currently advertised to be filled however, limited applications had been received. Emergency department management told us that they focussed on career development and staffing culture to attract applicants.

Staff told us that the service had low rates of bank and agency nurse use, with any additional staffing need being filled by overtime from current members of staff. It was acknowledged by staff that this however increased working pressures on staff overall.

At our last inspection we told the trust that it must ensure all relevant staff have completed Paediatric Advanced Life Support (PALS) when supporting paediatric provision in the emergency department. We also told the trust that it must review the service's paediatric staffing provision.

During inspection we noted that there was no paediatric nurse provision within the department after 5pm. , however the department had taken steps to mitigate this risk and meet relevant standards.

After 5pm, for any paediatric patients who attended the department, nursing provision was available from the hospitals children's ward, in order to keep children safe. In addition, we noted that all band six nurses had completed the paediatric life support qualification and there are always two band six members of nursing staff on shift, overnight.

This supported appropriate and safe treatment for paediatric patients who attended the department overnight.

Medical staffing

The service did not always have enough medical staff at consultant and junior doctor level.

The need to monitor the provision of medical staff was recognised by managers who regularly reviewed staffing levels and skill mix to manage any potential risks and provide medical staff with appropriate support. Monitoring of staffing levels was undertaken to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff overall to keep patients safe with a skill mix of medical staff on each shift and reviewed this regularly.

In September 2021, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were both lower than the national England average.

The staffing skill mix for the 49 whole time equivalent staff working in urgent and emergency care at the University Hospitals of Morecambe Bay NHS Foundation Trust, was as follows;

Whole time equivalent for consultant level was 18% in total, which was below the England average of 29%. Middle grade level was 54% in total, which was above the England average of 15%. Registrar grade level was 18% in total, which was below the England average of 36%. Junior grade level was 10% in total, which was below the England average of 20%. *(Source: NHS Digital Workforce Statistics).*

This was for all emergency departments and could not be separated between different locations.

This meant that there was increased staffing within the middle bands, to offer opportunities to support consultants and develop their own staff.

Urgent and emergency services

We reviewed staffing rotas for consultant cover and noted that this was appropriate for most shifts, within the previous four weeks of the inspection. A vacant consultant post was being taken up at the beginning of May 2022.

Records

Records were not always stored securely.

During our inspection we observed that several staff log in cards were left in computer keyboard terminals, when staff had left their desks. Computer screens displaying patient details were not always locked. This meant that viewing or access to patient records or details could have been gained by unauthorised persons.

Medicines

The service used systems and processes to safely administer medicines.

An antibiotic guide was in place and prescribers knew how to access and apply it. Records showed that medicines were prescribed as per antibiotic policy for the management of sepsis.

Staff completed medicines records accurately and kept them up to date when administering medicines. Records we checked showed medicines were normally given on time and accurate records had been made.

Clinic rooms were clean, tidy and appropriately stocked with medicines. A specialised medicines cabinet was used within the department to store stock and out of hours medicines. The medicines fridge in the minor's area was out of order, but clear signage was used to show this. No medicines were in the fridge. Controlled drugs were stored and recorded safely.

Audits of the use of rapid tranquilisation had been recently carried out. This identified further training was crucial for the continued education of prescribers, nurses and pharmacists to ensure safe appropriate prescribing, administration and monitoring of rapid tranquilisation.

There was no clinical pharmacy support in the department to help clerk and check a patient's medicines. We were told that this is either completed at triage by the nurse or by the nurse in the treatment room. Systems were in place so that the nursing staff could access patients GP records through the computer system.

Patient Group Directions (PGDs) that was being used within the department were in date and had been reviewed. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff provided examples of incidents that would be reported and told us that they were encouraged to report various concerns as incidents for example, pressure sores or verbal or physical abuse toward staff.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff explained how an incident would be reported within the online incident report system.

Urgent and emergency services

The service had reported no never events within the department.

Staff were aware of and understood the duty of candour. Staff told us when they reported an incident, they were aware of the duty of candour. However, there was no section on the incident form, for them to record this.

Staff took part in departmental team meetings to discuss the feedback from incidents and look at improvements to patient care. Staff told us that learning from incidents or complaints would be shared within emails and team meetings. Reflective feedback would be sought about an incident or complaint from staff and discussion about improving practice or patient experience was encouraged.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff were aware the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed departmental policies such as for the escalation of acutely unwell patients. This policy suitably referenced national early warning score (NEWS) guidance and was within review date. This meant that staff had information needed to care for deteriorating patients.

Staff told us they knew where to access departmental and hospital policies, so that they were aware of processes and procedures.

We observed that copies of some policies were within information racks in the department for staff to quickly access, for advice and guidance.

Emergency department management told us that there were two clinical audit leads within the department to ensure that processes were followed and complied with. Information, including about compliance levels, was passed from the clinical audit leads to the department manager so that action could be taken, if needed.

Staff told us about the use of the triage system and how this incorporated observations and tests required, being done prior to patients moving to department cubicles or bays. This meant that the clinicians and nurses had a better picture of what was required when they met the patient for the first time. Staff highlighted to us that this was an efficient use of time, which bettered patient outcomes and experience, by assisting flow through the department.

Staff told us that at triage, every patient was screened for any mental health need. If required, a referral to mental health liaison was made for assessment.

Urgent and emergency services

Pain relief

Staff 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.

Following our last inspection, we told the trust that it must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes.

During this inspection we found that staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff assessed patients at triage for pain using a mild moderate or severe format with the ability to use a recognised 'faces' pain scoring tool. Ongoing pain relief was monitored during patient observations.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

We noted that the department completed national early waring scores (NEWS) and chart of pulse, respiratory rate, blood pressure, temperature (CPOTTS) audits. Actions were taken where an issue was identified. For example, the CPOTTS audits for the months of December 2021, January 2022 and February 2022 highlighted a low compliance of blood sugars being monitored. The trust provided us with evidence of learning from this and an action plan for improvement.

Following our last inspection, we told the service that they must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment.

At this inspection we found that the trust takes part in the quarterly Sentinel Stroke National Audit programme. The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence-based standards.

These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, July to September 2021. Overall, the outcomes for patients diagnosed with a stoke had improved.

Patient outcomes were gathered from the completion of Royal College of Emergency Medicine (RCEM) national audits. The audits included mental health outcomes as well as fractured neck of femur (broken hip).

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We found evidence of other disciplines collaboratively working into the department, for patient benefit. Staff told us about an example of a patient who had a mental health need and was a frequent attender of the department. During one attendance the patient was found to be pregnant and the staff linked with maternity services to provide on-going pre-natal mental health support.

Urgent and emergency services

Staff worked across health care disciplines and with other agencies when required to care for patients. The department had a number of pathways which could streamline patients to other healthcare disciplines direct from triage. This helped prevent patients waiting in the department for long periods of time, prior to being referred on.

Staff told us that they would liaise with the local authority, GPs and other specialist hospitals as and when required. An example of this would be, if a patient needed to be followed up in the community or transferred to a specialist hospital for ongoing care and treatment.

Staff told us that the department had received support for pregnant women who were found to be diabetic on review. Maternity staff would assess the patient in the department to provide support around diabetes management in pregnancy and arrange follow up appointments.

Access to physiotherapist input was via a bleep system, however advanced clinical practitioner support was also available, for example to provide crutches to patients. Staff told us the department had access to fracture clinic staff for advice or support, if required.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Consent to treatment was noted in the discharge notes. Staff told us that they would undertake mental capacity assessments, where it was suspected that a patient may lack capacity to consent to a treatment.

Staff were aware of what the deprivation of liberty safeguards (DoLS) were and where an authorisation may be needed for a patient. It was understood by staff that a deprivation of liberty safeguards authorisation was not to be applied for, whilst a patient was within the department. Royal College of Emergency Medicine (RCEM) DoLS guidance is that standard authorisations are not applied for when patient is expected to be discharged within a matter of hours or days, however the trust's policy about DoLS did not reflect this practice.

We spoke with a safeguarding manager on duty who told us that the team were always on hand to give advice and would attend where needed to investigate concerns or support staff to undertake capacity assessments.

Staff told us about the process of identifying who would make a best interest's decision for a patient if they were assessed as lacking capacity, this would be the clinician in charge of their care. Family or friends were consulted, where available, as part of this best interest's decision-making process, which is considered best practice.

Staff told us they were aware of a child who could have 'Gillick competence' and followed this law. Gillick competence is a phrase that refers to a legal basis, for a person under the age of 16, to be able to give their consent for care or treatment.

Urgent and emergency services

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness. Privacy and dignity, of patients was not always championed. Staff took account of individual patient needs.

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 observed nursing and medical staff speak compassionately and empathetically with patients, offering support where possible. However, we did observe that three patients were waiting in an ambulance handover area. Although mobile screens were available these were not used, which meant that the patients could be seen by staff and other patients. The location of ambulance handover was located next to the automatic external doors, which meant that when these opened patients were subjected to the cold air from outside.

Patients said staff treated them well and with kindness. Patients told us that staff were professional and caring. We observed a member of the nursing team deal extremely professionally with the care of a patient who was confused and becoming agitated. They used de-escalation techniques to prevent the patient becoming more agitated.

We noted that 'bed down boxes' were available to provide essential supplies to patients who were in the department for a long period. The boxes included a toothbrush, eye mask and ear plugs for more restful sleep.

Staff did not always follow policy to keep patient care and treatment confidential. Three patients told us that they did not feel their privacy was respected at triage, as their information could be easily overheard by other people in the waiting area.

We also observed a lack of privacy in the ambulance handover area. During handover, other patients could hear information about the patient that was being handed over.

Staff did tell us that patients whose first language was not English, could access interpreters where possible.

Understanding and involvement of patients and those close to them

Staff supported and involved 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. We observed examples of information that had been given to patients/family about diagnosis and treatment plans and also additional information had been given to help them understand them these better.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff explain the side effects of medication without the use of jargon and without instilling any possible fear in the patient. They answered questions in plain English.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw signs providing contact details for the patient advice and liaison service (PALS) to help patients who needed advice or wished to raise concerns about their care. Staff told us they would also signpost PALS to patients, where appropriate.

The department surveys included positive and negative feedback and were displayed for patient and staff view. In the same day emergency care area of the department we observed quotes, from patients/carers, on the information board. These included quotes such as; 'fantastic, friendly staff' and 'cheerful and reassuring staff'.

The information board also included; 'Positive Feedback – Excellent service' and 'Negative Feedback – Lengthy wait times'.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. We noted that the majority of services was available 24-hours a day throughout the year.

Facilities and premises were appropriate for the services being delivered. There was clear signage throughout the hospital which helped visitors find their way to all departments. The waiting area was appropriate in size and had enough seats for patients. We also observed a separate, smaller waiting area for children.

We observed that there were enough toilets for visitors to use, access to vending machines and there was an onsite hospital cafeteria.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us about the sepsis and stoke pathways that were in place, which had the aim of getting the right treatment to patients within the 'golden hour'. We were told that the department was currently looking to implement a specialist trauma pathway based on the 'golden hour' principle for sepsis and stroke.

The service relieved pressure on other departments when they could treat patients in a day. We observed that a same day emergency care (SDEC) unit had recently opened within the department and was assisting with reducing patient waiting times in the emergency department.

During our inspection we noted that 22 patients had been moved from the emergency department to the SDEC thus helping flow within the emergency department.

Urgent and emergency services

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on capacity caused by shortages of available beds within the hospital. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Following our last inspection, we told the trust that it must ensure that care is provided in line with national performance standards.

During this inspection we observed that managers monitored waiting times and made sure patients could access emergency services when needed, however staff told us that due to patient number and staffing pressures, the focus was on individual patient risk and safety rather than meeting four hour waiting standards. This meant that less unwell patients could wait longer, so that more unwell patients were prioritised.

On 7 March 2022, 136 patients attended the Furness General Hospital's emergency department and of these 25.8% were admitted. This was against a backdrop of 24.5% being the England average.

Ambulances remaining at hospital for more than 60 minutes was 5.7%, against a backdrop of 9.5% being the England average.

Patients spending less than four hours in the department was 67.6% against a backdrop of 73% being the England average and a national standard of 95%.

For the most recent month available of January 2022 the total median time for patients in both the trusts departments was 164 Minutes. Patients waiting 4-12 hours from the decision to admit was at 27%.

There were 268 patients who spent more than 12 hours from decision to admit to actual admission and the median time to treatment was on average 51 minutes, against the England average of 65 minutes.

As a result of the pressures as shown, in the data above, the service was not consistently able to meet standards.

The average handover time from an ambulance to the staff in the unit from arrival during the week commencing 7 March 2021 was 28 minutes. The service scored 45% against a target of 65% for patients to be handed over within a time frame of 15 minutes. Furthermore, the service scored 69% against a target of 95% for patients to be handed over within a time frame of 30 minutes.

During the week of our inspection the longest amount of time from arrival to patient handover from the ambulance crew was 4 hours and 9 minutes and the service received an average of 28 patients per day from ambulance arrivals.

Staff told us that flow within the wider trust meant that the department was not always in a position to admit patients, at the point of decision to admit due to limited bed spaces on wards or assessment units.

Bed management meetings took place throughout the day to determine what actions could be taken to move patients through the hospital in a manner that meet their needs and maintained their safety.

Escalation triggers regarding bed availability and demands on services, were discussed and assessed in accordance with the risk. This information was shared with senior managers.

Urgent and emergency services

Managers and staff did not always ensure patients did not stay longer than they needed to. Staff told us about triaging pathways which meant that patients could be streamlined to a specific department, reducing their time in the department. However, we did note that some patients had been in the department for over twelve hours.

Managers were aware of the importance of planning each patient's discharge as early as possible. Staff told us about the pressures that the department faced and how this had been compounded by the COVID-19 pandemic. Emergency department management told us that a high number of attendances at the department, could be more appropriately managed by a different healthcare professional or service such as a GP or accessing 111 services. This put additional pressure onto the service.

Prior to our inspection and continuing through the site visit, the trust had declared a status of Operations Pressure Escalation Level (OPEL) 4.

OPEL 4 means that pressure in the local health and social care system continues to escalate and there is increased potential for patient care and safety to be compromised. OPEL 4 allows for decisive action taken to recover capacity and ensure patient safety and represents the highest escalation level possible.

Over the two days of our inspection there was a marked decrease in the number of patients within the department on day one, than on day two.

On speaking with managers, they felt this was due to the OPEL 4 status and that different actions such as; admitting patients to assessment areas and wards that would not normally be appropriate, had been undertaken.

Managers told us that they would review how this difference had been achieved and try to replicate it as much as possible going forward. They also said they would de-brief the staff so that they could fully understand what circumstances had brought about the significant reductions in pressure in the department, that they had noticed.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the appropriate range of skills, knowledge and experience to carry out their roles. The emergency department was part of the medicine care group with a triumvirate leadership team in place. This comprised of a clinical director, associate director of nursing and associate director of operations.

At a local level there was a matron and a service lead who were visible within the emergency department. They were supported by an emergency department manager and a lead consultant for governance.

Urgent and emergency services

Staff told us that the leadership at a local level were visible to them and they were highly complementary of the support they received. emergency department management told us they got enough support from the executive team and the board, commenting that senior leaders were very approachable.

Leadership development opportunities were available, including opportunities for staff below team manager level. This was recognised as a key factor in attracting and retaining staff.

The local leadership team had a good knowledge of current priorities and challenges and took action to address them. They monitored the quality of the service on an ongoing basis and cascaded information as needed

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a clear vision and set of values as a priority. There were five core values, 'the five P's' being; patients, people, partnerships, progress and performance. There was a strategy for achieving priorities and developing good quality, sustainable care. The vision was displayed on notices.

As well as an overall trust strategy for 2019-2024 there was also a clinical strategy 2019-2024. The clinical strategy contained several objectives under the emergency and urgent care model. One of the objectives of providing a comprehensive model of same day emergency care (SDEC) had been implemented; the arrangement was in its fourth week at the time of the inspection.

Further objectives included areas such as ensuring an enhanced frailty assessment service was in place so that those who did present to the department were assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive older person assessments with a focus of returning the patient back to their place of residence as a preference to admission.

Senior managers told us that the main priorities would be to link into the integrated care system recovery strategy and to meet key performance indicators for emergency departments, such as four hour wait standards and ambulance turnaround times. However, there remained significant pressures on the department that meant, at the time of inspection, this had not been realised.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services.

Staff knew and understood the vision, values and strategy and how achievement of these applied to the work of their team.

The service had a strategy for meeting the needs of patients with a mental health, learning disability, autism or a dementia diagnosis. This promoted a better patient experience.

Urgent and emergency services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

At a local level, the staff felt the culture of the department was very open, honest and fostered a spirit of teamwork and camaraderie during challenging times. Staff advised us that they would have no hesitation in speaking with their line manager. Emergency department management told us that they operated an open-door policy for staff to speak with them and encouraged issues to be raised freely.

The service had also supported staff by recognising the additional pressures that they were under during the pandemic. There were arrangements in place for staff who needed additional emotional support, this included; a 'quiet place to be', drop in counselling/support sessions, access to occupational health, yoga sessions, a sleep clinic and access to cognitive behavioural therapy.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had effective structures, systems and processes in place to support the delivery of its strategy.

Papers for meetings and other committees were of a reasonable standard and contained appropriate information. There was a number of audits in place and these were reviewed in relevant meetings to ensure that the quality of the service could be determined, and action taken as needed.

Leaders were clear about their areas of responsibility. A clear framework set out the structure of service, division and leaders. Leaders used meetings to share essential information such as learning from incidents and complaints and to act as needed. There was a monthly medicine care group governance and assurance group meeting attended by the matron, clinical lead and service manager from each department. This meeting covered a standard agenda following the assurance slide deck from each department.

There were weekly medical leads meetings and a senior nursing group meeting where key messages were delivered from executive and board level and these were cascaded down to staff in the department through the learning to improve bulletin and daily huddles.

Staff understood their roles and responsibilities and what to escalate to a more senior person.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements.

Within the emergency department there was a weekly patient safety meeting to review incidents that were rated moderate or above to agree any requirements to record them as serious incidents and whether a root cause analysis investigation was required.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Departmental management was well-sighted on the issues facing the department. They could articulate the top risks that the service faced and the had relevant action plans in place to mitigate these.

Staff and managers confirmed that there were several inappropriate referrals, to the department from both GP's and 111 services. Emergency department management identified a specific example of this; patients were being directed toward the hospital as an urgent care centre, whereas there was no such provision. Locally, the department management escalated this to relevant senior levels above them, for awareness and feedback.

We reviewed the departmental risk register and noted that it contained a description of the risk faced, a risk score, controls in place to mitigate the risk, any actions required and who had ownership of the actions.

The top risks that the staff told us about, broadly corresponded with the entries that we reviewed within the risk register. Staff had access to the risk register and were able to escalate concerns when identified.

There were plans in place for emergencies and other unexpected or expected events. The trust had invested funds in developing a major incidents centre. This allowed a co-ordinated approach between all emergency services in the event of a major incident. We noted that when a major event had occurred, this had worked well.

There was also the facility to ensure that bronze, silver and gold command arrangements were in place. This ensured control and co-ordination arrangements for the planning, preparing for and responding to different emergencies, were robust enough.

There was a robust and up to date major incidents plan that included learning from other NHS trusts and serious events, that had happened elsewhere within the country.

We reviewed senior leadership team meeting minutes where key performance indicators were a standing agenda item. Performance management was promoted with the use of a WESEE model; Workforce, Effectiveness, Safety and Experience and Engagement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

Leaders regularly reviewed and improved the processes to manage current and future performance.

Leaders were satisfied that clinical and internal audits were enough to provide assurance. Teams acted on results where needed.

Urgent and emergency services

Staff in the department were committed to improving the facilities and environment for patients with dementia, mental health conditions and children. Staff told us about an example of this where, at a staff members suggestion, a more sensory friendly room was created for patients.

In addition, there had been improvements in relation to patient stroke and sepsis pathways, so that the 'golden hour' of treatment time could be achieved. The pathway was looking to be extended for trauma cases.

Senior leaders told us about the department's participation in COVID-19 research trials and had screened patients into appropriate programmes. Trust Doctors had also been involved in developing a new point of care COVID-19 testing device in collaboration with a local university and had received two external funding awards to support this work.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Furness General Hospital Urgent and Emergency Care

- The trust must ensure that patient's privacy is upheld. Regulation 10(1)(2)(a)
- The trust must ensure that patient records are stored in a secure manner and can be accessed by staff. Regulation 17(1)(2)(c)

Action the trust SHOULD take to improve:

Furness General Hospital Urgent and Emergency Care

- The trust should ensure that the minors waiting area and the paediatric provision of the department has sufficient staffing and patient oversight after 5PM. Regulation 12(2)(a)
- The trust should consider a system to monitor staff wellbeing in relation to usage of bank and agency, to assist in the prevention of staff burnout.
- The service should consider reviewing the arrangements for the implementation of the metal capacity act and deprivation of liberties safeguarding within the emergency department and align the trust policy to the practice.

Our inspection team

The team that inspected the urgent and emergency care service comprised a CQC lead inspector, a CQC team inspector, a CQC specialist adviser, a medicines optimisation inspector and a CQC inspection manager.

The team reviewed data and information available before the site visit, and information sent from the trust. The team spoke with a total of six patients, 11 staff and reviewed a total of 15 patient records at the site visit to Furness General Hospital and undertook observations throughout the areas visited.

The team that inspected the medical care service comprised a CQC lead inspector, a CQC team inspector, a CQC specialist adviser and a CQC inspection manager.

The inspection teams was overseen by Karen Knapton, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance