London North West University Healthcare NHS Trust

Northwick Park Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Critical care	Good
Maternity and gynaecology	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this focused inspection to follow up on the concerns identified in two Section 29A Warning Notices served in July 2018, following an inspection of the trust in June 2018. We Judged that the requirements of the warning notice had been met. The warning notices set out the following areas of concern, where significant improvement was required:

In maternity there were several concerns which we listed in our warning notice:

- We were not assured that there were robust systems in place to ensure that all the correct staff were bleeped on an ongoing basis.
- We were not assured that there was a system in place to ensure that the correct staff were bleeped at all times.
- We were not assured that systems were in place to ensure that unauthorised persons could not gain access to the maternity surgical theatres via use of the staff/theatre lift.
- We observed that the doors to the delivery suite from the theatres were not controlled by a secure access system.
- We were notified that the main doors to the maternity unit could be forced opened, allowing unauthorised persons to enter the building.

In critical care we found two concerns, which we listed in our warning notice:

- We were not assured that there were sufficient handwashing facilities to mitigate the risk of cross-contamination.
- We were not assured that the beds within critical care were appropriately located to enable staff to perform emergency lifesaving care and treatment.

Our key findings were as follows:

In maternity we found:

- Several improvements had taken place since the comprehensive inspection report published in August 2018.
- The main security issues in maternity had been addressed.
- The maternity service had installed new outer main doors which could not be opened by force.
- The estates team reconfigured the lifts in maternity to prevent public access into the theatres corridor.
- New doors had been installed between the delivery suite and theatres to improve the overall security within the maternity department.
- Access to the building and in particular to the delivery suite was controlled by 24 hour receptionists in the delivery suite who were able to monitor visitors via security camera.
- Security staff told us that they patrolled the building regularly to check on and remove any unauthorised persons who may have gained access to public corridors.
- A member of the estates team told us that they were continuing to review security systems in this area of the trust to see what further improvements could be made.
- Switchboard tested the bleep system twice a day and recorded and acted upon the outcomes.

However, there were also areas of poor practice where the trust needs to make improvements.

Summary of findings

- All information to the public regarding tailgating, which lifts to use and the closing times of the maternity link corridor was in English only. Senior staff we spoke with told us that work was in progress to get the signs translated into up to 3 other commonly spoke languages.
- It was still possible, because of the need to ensure safe evacuation of the building for members of the public to allow access to the building by pressing an access button. This was mitigated by the secure access systems into the maternity unit itself.
- There was no nominated list of relatives or friends or equivalent that an expecting mother could set up to control the people visiting the maternity department.

In critical care we found:

- The removal of two beds in critical care and the repositioning of the remaining furniture to allow staff to deliver emergency lifesaving care and other treatment effectively was completed promptly and efficiently.
- Additional hand washing facilities have been inserted into critical care to mitigate the risk of cross contamination.

In addition the trust should:

- Continue to ensure robust security measures are in place across the trust.
- Look at further ways of verifying and controlling people entering and exiting the maternity department building.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Critical care	Good 	• We have not reviewed the rating for this service because of the limited focus of this inspection. The rating therefore remains good overall.
Maternity and gynaecology	Inadequate 	• We have not reviewed the rating for this service because of the limited focus of this inspection. The rating therefore remains inadequate overall.

Northwick Park Hospital

Detailed findings

Services we looked at
Critical care and Maternity.

Detailed findings

Contents

Background to Northwick Park Hospital

Northwick Park Hospital was first inspected as part of a comprehensive core service inspection in 2014. Both the maternity services and critical care services were rated as requires improvement. After our most recent comprehensive inspection in June 2018 maternity services were rated inadequate and critical care was rated as good. The overall rating for the trust has stayed the same and was rated requires improvement.

In June 2018, we conducted a comprehensive inspection of the trust services. At Northwick Park hospital we found serious concerns with two out of the six core services we inspected; maternity services and critical care services. In critical care we identified serious concerns regarding cleanliness, infection control and hygiene. In maternity we found serious concerns with multiple aspects of security and the emergency bleep system. Due to these serious concerns we took immediate enforcement action and issued a section 29A warning notice to the trust. The trust was required to submit a detailed action plan outlining how these concerns will be mitigated, and this follow up inspection was undertaken to review the progress made.

Our inspection team

The team that inspected the services included a CQC lead inspector and an inspection manager. The inspection team was overseen by an inspection manager, and Teri Salt Head of Hospital Inspections.

How we carried out this inspection

We conducted this inspection, unannounced on 9 January 2019. Our focus was the action plan submitted after the 29A warning notices.

We visited the maternity department, critical care the high dependency unit. We also visited the information and communications technology (ICT) department and the estates department. We also spent time with the site management team and the maternity management team.

During our visit we spoke with approximately 18 members of staff, including senior management, nurses, security, ICT staff, estates and switch board staff.

Detailed findings

Facts and data about Northwick Park Hospital

Northwick Park Hospital is in northwest London. The hospital was opened in 1970 and serves a diverse population of over 550,000 people. The hospital serves both the London Borough of Brent and the London Borough of Harrow. The hospital is part of a trust that employs more than 9,000 clinical and support staff to provide a range of services including maxillofacial, orthopaedics, neurology, cardiology, paediatrics, elderly care and rehabilitation services.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Inadequate	Good	Good	Good	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Critical care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The critical care service sits in the surgery division and is managed by a clinical lead, a lead nurse and a matron. Critical care encompasses intensive care and high dependence levels of support. At Northwick Park Hospital, the critical care unit provides a total of 24 adult inpatient beds across two different floors and 6 inpatient beds with an additional two side rooms in the high dependence unit. We found critical care services good overall and requires improvement in the safe domain; we issued a Section 29A warning notice to this service.

Summary of findings

This was a follow up inspection of the critical care department to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in June 2018. We judged that significant progress had been made. We judged the requirements of the warning notice had been met.

We have not reviewed the rating for this service because of the limited focus of this inspection. The rating therefore remains good overall.

At our initial inspection in June 2018, we were concerned about the number of clinical hand wash basins per bed space. Each bed space should have their own hand wash basin, which was not the case when we inspected. We observed five bed spaces sharing three hand-wash basins. Moreover, the bed spaces were less than half the size of that recommended with a new build critical care unit. This space did not allow staff to access patients from all sides of bed; to manoeuvre the patient, themselves and equipment safely and to allow five members of staff to attend to a patient in an emergency.

We found:

- All changes had taken place since the comprehensive inspection published in August 2018 including staff changes and reconfiguration of premises.
- Each bed had their own designated hand wash basin.

Critical care

- Each bed had a large bed space to provide optimal care and emergency treatment.
- Beds could be accessed on all sides to provide emergency care and treatment when required.
- Good adherence to trust action plans.

Are critical care services safe?

Requires improvement

Cleanliness, infection control and hygiene

- At our initial inspection we reported that there were not enough hand wash basins per bed space. We spoke to the head of estates, who informed us that as soon as this was reported by the Care Quality Commission plans were put in place immediately to rectify this. Work was carried out over the weekend and the additional hand wash basins were fully commissioned by 01 August 2018.
- This meant that all beds within critical care has their own designated hand wash basins. The trust also took the initiative to ensure that all beds within the high dependency unit also had their own hand wash basins.

Environment and equipment

- At our initial inspection we reported that the bed spaces were less than half the size of that recommended with a new build critical care unit. We spoke to the head of estates who informed us that both critical care and the high dependency unit had been reconfigured, to ensure compliance with recommendations for a new build critical care unit.
- Two beds were removed from critical care and the high dependency unit, to create large bed spaces per bed. This meant that critical care reduced their beds from five to three beds and the high dependency unit reduced their beds from six to four beds. We observed both areas and found spacious and bright working environments with large bed spaces.
- Staff we spoke with said that equipment had been repositioned and that they were no longer hitting their heads whilst trying to provide optimal and emergency care for patients.
- Staff we spoke with were happy with the new working environment for themselves and for the patients.
- Staff reported that patients requiring rehabilitation had a lot more space for treatment.

Critical care

- Staff previously reported that doctors would usually request the patient to sit up, but that this had often been difficult due to the minimal space however, this issue has now been eliminated.
- Staff we spoke to reported that medical staff noticed a difference and were happy with the new layout and additional space.

Are critical care services effective?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Are critical care services caring?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Are critical care services responsive?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Are critical care services well-led?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Maternity and gynaecology

Safe	Inadequate
Effective	Good
Caring	Good
Responsive	Good
Well-led	Inadequate
Overall	Inadequate

Information about the service

The maternity service at Northwick Park Hospital sits under the women and children's division and consist of an obstetric-led delivery suite, a midwife-led birth centre and Florence obstetric ward. There is also a fetal medicine unit, day assessment unit, maternity theatres and recovery and an obstetric observation bay. The hospital has 69 maternity beds made up of 19 beds on the delivery suite, 31 beds on the Florence obstetric ward and 19 beds on the midwife-led birth centre. All located at Northwick Park Hospital. We last inspected Northwick Park maternity services in June 2018. We found maternity services inadequate overall, and we issued a Section 29A warning notice to this service.

Summary of findings

This was a focused inspection to check on the trust's progress against our warning notice. As such it does not change the rating given at our previous comprehensive inspection, at our initial inspection in June 2018, we were concerned about the staff in maternity and the trust's switchboard team. The switchboard team were responsible for dispatching staff in the event of an emergency, and had inconsistent knowledge of responding to an obstetric or paediatric crash call. There were three lifts in the maternity building. One of the lifts was a theatre lift and could only be called by staff with a swipe card. However, we saw members of the public get into the theatre lift on three occasions. There was no security on the doors between the delivery suite and theatres. This meant there was a risk of unauthorised people gaining access to these areas via the theatre lift. There was no security system to ensure only authorised staff could gain access from the delivery suite to theatres. There was a lack of tail gating notices on all wards and departments. These are notices at the entrance to wards and departments that remind staff and the public not to allow other people to access the ward by entering when the doors are opened. This was a follow up inspection of the maternity department to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in June 2018. We judged that significant progress had been made. We judged that the requirements of the warning notice had been met.

Maternity and gynaecology

We have not reviewed the rating for this service because of the limited focus of this inspection. The rating therefore remains inadequate overall.

We found:

- All changes had taken place since the comprehensive inspection published in August 2018 including new systems, staff changes and reconfiguration of premises.
- The main security issues had been addressed, the lifts had been reconfigured and the maternity department had installed new doors to the main entrance.
- A new door that had been put in place since the inspection to stop patient flow between the delivery suite and theatres.
- The bleep system for emergencies had been thoroughly reviewed and robust processes were in place to test the system.
- Access to the building and in particular to the delivery suite was controlled by 24 hour receptionists in the delivery suite. The reception desk was staffed 24-hours a day, 7 days a week, and the receptionists monitored visitor access using a security camera.
- Security staff told us that they patrolled the building regularly to check on and remove any unauthorised persons who may have gained access to public corridors.
- A member of the estates team told us that they were continuing to review security system in this area of the trust to see what further improvements could be made.
- The bleep system for emergencies had been thoroughly reviewed and robust processes were in place to test the system.
- The maternity department was now conducting their own random bleep tests to ensure and test their own procedures.
- The maternity department was conducting a snatch baby exercise to ensure that staff knew what to do in such an event.

However:

- All information to the public regarding tailgating, which lifts to use and the closing times of the maternity link corridor was in English only.
- All information to the public regarding tailgating, which lifts to use and the closing times of the maternity link corridor was in English only.
- It was still possible, because of the need to ensure safe evacuation of the building for members of the public to allow access to the building by pressing an access button. This was mitigated by the secure access systems into the maternity unit itself.
- The door release button inside the main doors to the maternity department was accessible to the public. This meant that staff could not have full control on who was entering and exiting the department. We were told that members of the public were using this button to allow people in who were banging on the doors. This was in despite of reception staff telling members of the public to not allow people in for their own security.
- There was no nominated list of relatives or friends or equivalent that an expecting mother could set up to control the people visiting the maternity department.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

Environment and equipment

- At our initial inspection we reported the main doors to the maternity department could be forced open. We spoke to the head of security who informed us that the estates team had now installed new doors for the maternity department.
- These doors were more secure than the previous doors as there was a physical mechanism in the form of bolts within doors that held the doors shut. This meant that it would be difficult to prise these doors open with force.
- These doors were now locked between 7pm and 7am every day. Members of the public were required to ring a bell to gain access to the building. A CCTV camera and intercom system was positioned in the delivery suite at the reception desk, and the receptionist could see and talk to the person who activated the bell. This meant that reception staff were able to allow or deny access into the maternity department.
- The trust had also restricted the public access to and from the link corridor joining the maternity department to the rest of the hospital. Clear signs in English were in place to inform both staff and the public that this corridor could not be accessed from 7pm to 7am every day.
- The entry and exit door to the delivery suite remained secured at all times and only staff and the receptionist could allow members of the public in and out. Also, a panic button was now installed in the delivery suite in the reception area that was directly linked to the security team.
- At our initial inspection we were concerned that the public lifts in maternity opened at both ends. This is because the rear doors to these lifts opened directly into the corridors within theatres.
- At our follow up inspection we saw that these lifts were now electronically reconfigured so that the lifts would not open to allow the public into the theatre corridor. This work was completed in November 2018.
- The lift used for theatres from within the maternity department now had a sign that said 'This is not a public lift. This lift can only be used for emergency and staff. Please use either of the other two lifts which are specifically for public use.' This sign was only printed in English.
- This meant that there was now a designated lift for theatres, for the use of emergencies.
- This lift could only be called by members of staff, and once inside the lift staff required the use of their ID badge to move between floors.
- In emergencies a key that was held in the maternity department could be used to open this lift.
- We looked at a Standard Operating Procedure (SOP) that detailed the action to be taken if any lift was out order in maternity. This was updated on 12 October 2018 to be in line with the new lift configuration.
- The SOP clearly outlined actions in the form of a flow chart and this information was available to staff on the intranet and on staff notice boards. Staff we spoke with were confident in these procedures.
- At our initial inspection we noted that there was a direct access to the delivery suite from theatres. The head of security showed us a new door that had been put in place since the inspection to stop patient flow within these areas.
- This door could only open via swipe access by staff.
- During out initial inspection we were concerned that members of the public could tailgate staff members into restricted areas. On our follow-up inspection we observed numerous tailgating signs throughout the maternity department to remind staff to not allow members of the pubic to tailgate.
- We observed staff using their swipe access and ensuring that they were not being followed into a secure area.

Assessing and responding to patient risk

- At our initial inspection we were concerned that the correct staff groups were not bleeped, when required during an emergency. The emergency bleep list had now been reviewed by senior staff across the trust and ensured that the correct staff groups were enlisted to the relevant bleeps.

Maternity and gynaecology

- We spoke with senior management staff in maternity who told us that immediately after our June 2018 inspection they has liaised with the clinical director and clinical leads to ensure that the correct staff groups were on the correct emergency bleep list. This was also relayed to the information and communications technology (ICT) department and switchboard.
- We spoke to staff in switchboard who told us that bleeps were routinely tested twice a day by the switchboard team and outcomes were recorded. These outcomes were reported to the operations manager. Staff reported good outcomes to these bleep tests even though a live bleep could be bleeped between fifty to sixty times a day. This showed that staff were taking the bleep test seriously.
- We spoke with staff in switchboard who told us that all updates to bleep lists were handed out to them on a piece of paper. This was then logged and filed in their emergency log book for patient arrest. Each member of staff had their own copy of the log book.
- Staff we spoke with in switchboard were aware of the incident that occurred during our inspection regarding a paediatric emergency call, staff had been informed and debriefed by their supervisor of this incident.
- We spoke to the operations manager and we were informed that when bleeps were not responded to, the bleep holder was marked as a non-responder on the bleep test sheet by the switchboard team.
- The switchboard team then raised this with their supervisor or manager. This was then escalated to the relevant divisional general manager and an incident reporting form was completed. We saw that this was documented in the governance process map for bleep testing created by the associate director for ICT.
- We were informed by the associate director for ICT that there were not many incidents reported as staff groups took the bleep tests seriously.
- We spoke to a matron in gynaecology who was aware of the incident that occurred during our inspection in maternity. The matron reported that this incident was picked up in the weekly risk management meetings and in the senior team management meeting.
- Staff we spoke with in maternity told us that since the inspection there had been other maternity emergencies requiring the assistance of the switchboard team, and the right staff groups were called to the incident.
- We looked at the Northwick Park Hospital emergency alerts information sheet, which had been newly created since the inspection and had gone live in September 2018. The information sheet relayed information such as the phone number to call in an emergency and the correct phrases to use per patient group emergency. For example, for a neonatal emergency call the switch board would bleep the neonatal team and paediatric team. This information sheet was widely available to staff, and could be found on the intranet and on the hot topic board in the staff room.
- Senior staff we spoke with in maternity had liaised with other trusts regarding the testing of the bleep process. The hospital found that their procedures were just as robust as those in other trusts.

Are maternity and gynaecology services effective?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Are maternity and gynaecology services caring?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Are maternity and gynaecology services responsive?

Good

This inspection was confined to follow up the warning notice and we did not gather evidence for this question.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Inadequate

Management of risk, issues and performance

- In our initial inspection we were concerned about the number of security issues in maternity. Staff we spoke with in the maternity management team informed us that the department had conducted a snatch baby role play exercise. This was done randomly and showed that staff had good knowledge of the snatch baby policy. Feedback reported from this exercise was that staff must act straight away. This exercise was planned to continue to happen randomly to ensure good knowledge and skills were upheld.
- In our initial inspection we were concerned about poor staff awareness of the public having direct access to the theatre corridors via the lift. We looked at risk management newsletters that was sent out to all the staff via email immediately after the inspection in June 2018. The newsletter informed staff of the risks identified by the CQC inspection team and all the ways these risks were going to be mitigated.
- Senior staff we spoke with in maternity reported that there was a good rapport with the on-site security team and the communications team in ICT, which had strengthened since the inspection. The maternity department now received a weekly security report from the head of security every Monday.
- Senior staff we spoke with in maternity told us that the department was also running their own bleep test. Testing the response to maternity emergencies and that the right staff groups were present. This was also done randomly with good outcomes; however, these outcomes were not recorded.
- Senior staff we spoke with in maternity had taken the initiative to liaise with other trusts in regard to their security measures. Since our inspection, they had been looking at improving security issues as a long-term approach rather than a short-term fix.
- We observed security staff patrolling the hospital including in the maternity department. We spoke to a member of the security team who informed us that electronic patrol guns were used to record proof of presence within each department and on each floor. We looked at the weekly maternity security update reports that were provided by the head of security. The reports included information pertinent to maternity for security, daily patrols, lifts and the maternity doors.
- We saw that bleep testing exception reports was a standing agenda item at local risk management meetings in maternity.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The hospital should continue to look at all measures to improve the buildings security.
- Look at ways of verifying and controlling who is entering and exiting the maternity department considering the use of nominated relatives and friends of mothers
- Consider measures to reduce the number of people needing to be in the main waiting area to limit the incidences of them giving access to the building.