### North West London Hospitals NHS Trust
### Northwick Park Hospital

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<tr>
<th>Region:</th>
<th>London</th>
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<tr>
<td><strong>Location address:</strong></td>
<td>Watford Road</td>
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<td>Harrow</td>
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<td>Middlesex</td>
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<tr>
<td><strong>Type of service:</strong></td>
<td>Acute services with overnight beds</td>
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<tr>
<td></td>
<td>Hospital services for people with mental health needs, learning disabilities and problems with substance misuse</td>
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<td>Rehabilitation services</td>
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<td>Long term conditions services</td>
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<td>Diagnostic and/or screening service</td>
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<td><strong>Date of Publication:</strong></td>
<td>November 2011</td>
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<td><strong>Overview of the service:</strong></td>
<td>Northwick Park Hospital is a major acute</td>
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<td>hospital in north west London, managed by North West London Hospitals NHS Trust. The Trust provides acute hospital services to more than half a million people living across the London boroughs of Brent and Harrow, as well as patients from all over the country.</td>
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Our current overall judgement

Northwick Park Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 31 August 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

The majority of patients we spoke to during our visit to the hospital were very positive about the care and treatment they had received at Northwick Park Hospital. 'Staff are excellent and look after me well' was typical of the comments we received. Patients had been treated with dignity and respect and felt fully informed about their treatment. Treatment was explained in a way that patients could understand. Views on the meals provided varied greatly with some describing the food as 'amazing' and 'pretty good', whilst others said it was 'not very appetising' or even 'inedible'. Patients felt safe in the hospital and confident in the skills of staff and care provided by them.

What we found about the standards we reviewed and how well Northwick Park Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patients were treated with dignity and respect by staff and understood the care and treatment provided to them. Sufficient information was provided to enable them to make decisions in relation to their care and treatment. Care was centred on the patient and, as a result, their needs were met. Overall, we found that Northwick Park Hospital was meeting this essential standard.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
Generally care and treatment were explained to people in a way in which they understood and suitable arrangements were in place for obtaining valid consent. However, in some instances documentation in relation to decisions not to attempt resuscitation of patients was incomplete. It was not clear whether patients or their relatives had been consulted on the decision taken.
Overall, we found that Northwick Park Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

Relatives and patients were positive about the quality of care and treatment they received. Patients received care and treatment that met their needs and minimised risks to their safety.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 05: Food and drink should meet people's individual dietary needs**

Patients had different opinions of the meals provided to them. There were processes in place to identify and monitor people who were at risk of poor nutrition and hydration and minimise interruptions during meal times. As a result patients were protected from the risks of inadequate nutrition and dehydration.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 07: People should be protected from abuse and staff should respect their human rights**

Staff understood how to recognise and respond to concerns in relation to safeguarding vulnerable adults. Patients felt safe and were protected from abuse or the risk of abuse.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 09: People should be given the medicines they need when they need them, and in a safe way**

Patients were provided with information on the medication prescribed for them. Generally patients were protected against the risks associated with the unsafe use and management of medicines. However, not all medication had been stored safely in paediatrics. Expired medication was found in a drugs fridge and fridge temperatures were not monitored consistently on all wards. As a result patients could have been put at risk of receiving ineffective medication.
Overall, we found that Northwick Park Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

When the needs of patients changed procedures were in place to enable extra staff to be brought in. There were sufficient numbers of suitably qualified staff on duty to ensure patient’s safety and meet their needs.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

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

Staff were supported to perform their role effectively and had undertaken training in areas relevant to their professional role and development. Patient's needs were met by competent staff.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

The quality of service provided to patients was monitored regularly. There was evidence of learning and changes in practice in response to analysis of complaints and incidents. Risks to patient safety were managed effectively.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 17: People should have their complaints listened to and acted on properly**

Although information on how to complain was not clearly displayed on all wards and departments, patients felt able to raise issues of concern with staff and were confident they would be dealt with. Learning had taken place and changes made in service delivery in response to complaints.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Outcome 21: People’s personal records, including medical records, should be accurate and kept safe and confidential**

Health care records were stored securely. Generally they were accurate and contained detailed information relevant to patients’ care and treatment.
Overall, we found that Northwick Park Hospital was meeting this essential standard.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

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

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

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

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01:
Respecting and involving people who use services

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

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke to patients on several wards and in the Accident & Emergency department (A&E). Everyone told us they had been treated with dignity and their privacy respected. A patient in A&E told us, 'staff are very good, they pull the curtain when needed', which was typical of the comments we received.

Patients and their relatives we talked to confirmed that they had been consulted and staff had kept them updated regarding their progress. A patient on Hardy Ward agreed that nurses took the time to explain his care to him and another patient said that her treatment had been fully explained. She told us, 'I am involved in my care and the consultant asked me if I had concerns about the treatment'.

We saw staff pulling the curtains around the beds of patients before delivering care and treatment; this ensured that patients' privacy was respected.

During the visit we observed that staff were respectful towards patients and spoke to them in a sensitive and caring manner. Staff showed respect for people's religious and cultural beliefs.

Other evidence
Staff told us that they were aware of the need to ensure that all patients were treated with respect and dignity regardless of their background. The initial assessment of patients included their dietary requirements, preferred language for communication and their religion. Staff told us that if a patient was admitted from a care home and was unable to explain their own needs, they would contact the home to obtain more information about the patient's individual preferences.

In Fielding ward, we noted that there were posters on the doors of bedrooms instructing staff to knock and ask permission before entering patients' bedrooms. There was a notice on each curtain that said: ‘Stop – ask permission before entering. Respect the patient's privacy and dignity’. We saw health care records in Jack’s Place, the paediatric ward, which included a dignity and privacy document. This document stated the young person's wishes on which gender and age section of the ward they wanted to be in.

We saw that patients were in bays with people of the same gender on all wards we visited.

Information was provided to patients and relatives on the wards but this was not always available in written form. Leaflets providing information about the wards and services were available on some wards, for example, Fielding Ward. In Dickens Ward staff said they gave little slips of paper to relatives containing details of how to contact the ward and visiting hours. A patient we spoke to confirmed she had received the information slip. The Trust told us that a new in-patient information booklet was about to be launched across the hospital. A guidance information leaflet for relatives and carers was being developed that aimed to include information on how to arrange a meeting with the patient's medical team and the interpreting services available.

**Our judgement**

Patients were treated with dignity and respect by staff and understood the care and treatment provided to them. Sufficient information was provided to enable them to make decisions in relation to their care and treatment. Care was centred on the patient and, as a result, their needs were met. Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 02: Consent to care and treatment

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

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

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<td>The provider is compliant with Outcome 02: Consent to care and treatment</td>
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What people who use the service experienced and told us
Patients and their relatives told us that staff explained care and treatment to them and obtained the patient's consent before carrying out procedures or providing treatment. For example, one relative in A&E told us, 'they explained things to us in layman's terms'. A patient on a ward told us, 'they explained about what they wanted to do and why, it was understandable' and another said, 'they consult with us and let us know what is happening'.

Some patients told us they had been asked to sign a consent form before undergoing a surgical procedure. Several patients said that nurses and doctors always asked for permission before care or treatment was carried out.

One patient told us he was confident that if he did not want to take his medication then staff would respect his decision.

Other evidence
Staff were aware of the need to obtain consent before treatment was provided. We saw signed consent forms in patient healthcare records. Care records documented where verbal consent had been obtained.

Staff told us that capacity assessments were carried out where there were concerns
that a patient was not able to give informed consent. We saw a 'best interests' assessment for a patient who was unable to give consent. Discussion of the patient's care with her sister was documented. On Fielding Ward, staff informed us that two patients had recently been referred to the Independent Mental Capacity Act Advocate. Staff also confirmed that work was being undertaken across the Trust to improve capacity assessments as part of improved care documentation. The Trust told us that a new nursing core assessment booklet, which included capacity assessments, was due to be launched soon and was currently being piloted on Dryden Ward.

Staff we spoke to had some understanding of the Mental Capacity Act but had not attended formal training in this area. The Trust had planned a programme of training for staff about the requirements of the Act which was due to begin at the end of September 2011.

During our review of patient health care records we saw some examples of where a decision had been taken not to attempt to resuscitate the patient in the event of a cardiac arrest. On Fielding Ward staff told us that decisions regarding resuscitation were reached following discussion between the consultant and the patient's family where the patient lacked capacity. We saw evidence of this in one patient's health care records. The relative's views were recorded in the notes.

On Evelyn ward, in one patient's records included a decision not to attempt resuscitation. However, there were no details on the form indicating who had been consulted in the making of this decision. On Hardy Ward we saw a similar form completed for a patient documenting a decision not to attempt the resuscitation of the patient. The form was signed by a doctor but there was no record of any attempt to discuss the decision with the patient's family. Lack of clear documentation in relation to decisions about resuscitation raised concerns that staff were not always taking patient's and relative's wishes into account when making decisions about care and treatment.

**Our judgement**
Generally care and treatment were explained to people in a way in which they understood and suitable arrangements were in place for obtaining valid consent. However, in some instances documentation in relation to decisions not to attempt resuscitation of patients was incomplete. It was not clear whether patients or their relatives had been consulted on the decision taken.
Overall, we found that Northwick Park Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
What the outcome says
This is what people who use services should expect.

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

What we found

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

Our findings

What people who use the service experienced and told us
Patients were generally happy with the care they received and nurses were described as respectful and polite. A relative in A&E told us, 'we are very happy with the care'. Patients on James Ward and Dickens Ward were also positive about care. For example, one patient said, 'staff are excellent and look after me well', and another said, 'staff are friendly, treat me with respect and have a good understanding of my cultural needs'. A third patient described staff as 'unfailingly kind'.

We received very few negative comments from patients. One patient told us she had had to wait in A&E for five hours before being admitted to the ward and that there had been nowhere for her to lie down. However, she was very positive about her subsequent care on Hardy Ward. Another patient on the same ward said that staff were very attentive and understood her needs.

Patients told us that pain was controlled and they did not have to wait long if they required pain relief.

Patients we spoke to in A&E told us that they had not been waiting very long to be seen. They told us that staff had informed them it would be about 30 minutes before they were seen. On our return to the waiting room a few minutes later, we noted that they had been attended to.

Parents we spoke to in Jack's Place, the paediatric ward, said they had been kept up to date by staff in relation to their daughter's progress. They felt she had been well cared
for on the ward. One mother said that she felt her opinion was 'listened to' by staff. We also saw artwork displayed that had been completed by the children on the ward. The children had written phrases such as, 'the very best ward ever' and 'the place where you want to be' on their pictures.

In Jack's Place we saw toys and equipment provided for children of all age groups. The environment was bright and cheerful and pull down beds were provided to enable parents to stay with their children.

We observed positive and caring interactions between nurses and patients on all the wards we visited. Staff were regularly present in the bays, responded quickly to patients' needs and had time to talk with them. Patients were cared for in single sex bays on the wards and each bay had its own toilet facilities.

Other evidence
We reviewed patient healthcare records on a number of wards. We found detailed assessments of patients' needs including discharge risk assessments and pressure area assessments. Care plans were in place to address identified needs. For example, patients assessed as being at risk of pressure sores were provided with pressure relieving mattresses. There was evidence of multidisciplinary involvement in care and treatment. Daily progress notes had been completed by staff.

On the day of our visit there were two patients in A&E who had been there for more than four hours. Staff explained the particular circumstances of these patients and the reasons for the delay.

Staff on Dickens Ward, an acute assessment unit where patients could stay for up to 48 hours, told us that patients could be moved to another ward at any time when a bed became available. This could include transfers late at night or even while the patient was eating a meal which was not considered ideal.

Our judgement
Relatives and patients were positive about the quality of care and treatment they received. Patients received care and treatment that met their needs and minimised risks to their safety.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 05: Meeting nutritional needs

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

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We spoke to patients about the food provided to them on the wards. Some patients stated that the meals provided were satisfactory while others were less happy. For example, one patient said of the meals: ‘the food is amazing, lovely, I had Moroccan lamb tagine yesterday’. Another praised the food and said it was, ‘good and appealing’. However, other patients did not like the meals provided. Some of the negative comments we received included 'inedible' and 'not very appetising'.

Some patients commented that portion sizes were too small and the Asian dishes were too spicy. The meals were also described as 'predictable' and 'lacking in variety'. However, another patient told us a range of choices were available including Asian food, vegetarian food, low fat and low fibre options. This was confirmed by the meal menu. One patient said they struggled with understanding the diabetic meal options available to them on the menu

Patients told us that drinks and snacks were available when they wanted them. One patient told us he was given tea three or four times a day and staff would make cups of tea on request. We saw jugs and drinks of water left within reach of patients. Some patients, however, were unhappy with the long gap between the evening meal and breakfast the next morning.

At lunchtime we observed staff assisting patients to eat their meals where this was appropriate to the patient's needs. We also observed a member of staff going through the menu for the next day with a patient and helping them to make a choice of meals. We saw that protected meal times were being implemented and patients confirmed that
they were not interrupted by doctors or others when eating their meals. Patients who required assistance with their meals were identified by a red tray.

**Other evidence**
We saw that nutritional assessments had been carried out soon after patients were admitted and normally within 24 hours of admission. This ensured that patients requiring extra assistance with eating and drinking were identified. Where food and fluid intake and output monitoring was taking place forms were generally completed. Patients were weighed regularly.

We saw that a screen was placed outside the front door of wards during mealtimes to remind people that meals were being served and patients were not to be interrupted.

Staff told us that diabetic patients were helped to identify low sugar options on the menu rather than being provided with a ‘diabetic diet’ choice.

**Our judgement**
Patients had different opinions of the meals provided to them. There were processes in place to identify and monitor people who were at risk of poor nutrition and hydration and minimise interruptions during meal times. As a result patients were protected from the risks of inadequate nutrition and dehydration. Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 07: Safeguarding people who use services from abuse

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

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement
The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We observed staff interacting with patients and relatives in a respectful manner. Patients told us they had been treated well by staff. They felt safe and able to ask any questions they wished to about the care provided. One patient said, 'If I am worried, they (the staff) are all approachable'. This was typical of the comments made to us.

Other evidence
All staff on the paediatric ward had undertaken child protection training and were aware of the child protection policy and procedures. A consultant gave us an example of a child death in A&E which had been referred to the police and the coroner in line with procedures.

Staff were able to describe signs of possible abuse and said they would inform their manager of any suspicions. Staff confirmed that these issues were covered during induction at the beginning of their employment.

We saw a training timetable for staff which showed that study days had been arranged in safeguarding vulnerable adults. The training programme had begun in September and several staff told us they were due to attend.

Our judgement
Staff understood how to recognise and respond to concerns in relation to safeguarding vulnerable adults. Patients felt safe and were protected from abuse or the risk of abuse. Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 09:
Management of medicines

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

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement
The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We asked patients about the medication they were taking and whether they knew what it was for. One patient told us that a nurse came round three or four times a day with his medication and explained what the different tablets were. Others said that the side effects of the medication had been explained to them in a way they could understand.

Several patients we spoke to told us that their pain was well managed. For example, one patient said that staff were quick to respond to requests for pain medication. Another said, 'I am not in any pain'.

We observed a pharmacist explaining medication to one patient who was about to be discharged. The explanation included the side effects of the medication, what they were for, the dose and the way to take them. The patient appeared reassured by this.

We saw that no medicines had been left on patients' bedside lockers.

Other evidence
Staff were knowledgeable about procedures for the administration of medication. Keys to the medication cupboards were kept safely. Where medication trolleys were used these were secured to the wall when not in use.

On the wards we visited controlled drugs were stored in double locked controlled drugs cabinets and firmly secured to the wall. Accurate records had been kept in the
controlled drugs book. Stock levels had been checked daily and signed. We checked
and noted that the controlled drugs were administered in accordance with the
prescribing doctors' instructions as stated on the medication charts.

We checked a number of medications in the drug cupboards on all wards and found
that they were within date. On Evelyn Ward, however, we noted that two medicines
which had expired were still kept in the drugs fridge (diazepam and insulin). Staff were
surprised to find them there and arranged to have them returned to the pharmacy for
disposal. Liquid medication bottles on James Ward had not been dated when they were
opened.

The temperatures of fridges used to store medication were checked daily on most
wards except James Ward where the temperature of the medicine fridge had been
recorded on only eight of the 31 days in August 2011.

In Jack's Place, the paediatric ward, we found one wall-mounted cupboard full of
medication which was unlocked. A nurse explained that it had been like that for about a
week. The lock would not work and they were waiting for maintenance to fix it. Although
the cupboard was out of reach of children the medicines had not be kept safely. Staff
immediately emptied the cupboard and moved the contents to another lockable area.

We checked a number of patient medication administration records. These showed that
medications were mostly signed for when given, although there were a few omissions
on James Ward. The dose and indications for administering were recorded. As required
(PRN) medication had been administered in accordance with the prescribing doctors'
instructions. Staff told us that the pharmacist visited the wards daily to check on the
arrangements for the administration of medication.

Newly qualified staff were given additional training on how to give intravenous
medication safely. They were supervised administering medication five times before
being declared competent.

Our judgement
Patients were provided with information on the medication prescribed for them.
Generally patients were protected against the risks associated with the unsafe use and
management of medicines. However, not all medication had been stored safely in
paediatrics. Expired medication was found in a drugs fridge and fridge temperatures
were not monitored consistently on all wards. As a result patients could have been put
at risk of receiving ineffective medication.
Overall, we found that Northwick Park Hospital was meeting this essential standard but,
to maintain this, we suggested that some improvements were made.
Outcome 13: Staffing

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

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

What we found

Our judgement
The provider is compliant with Outcome 13: Staffing

Our findings
What people who use the service experienced and told us
Most patients were satisfied with the number of staff on duty and with the competence of the staff caring for them. For example, one patient said, 'they (the staff) are excellent and know what they are doing. I'm surprised how many staff there are'. Another said, 'I think there are enough nurses, I usually don't have to wait too long'. A few patients saw things differently and thought their ward was understaffed. One patient on Hardy Ward said that when he used the call bell he could wait a long time for anyone to come. Another patient on the same ward, however, said that staff responded within 'two minutes' to the call bell and that there was a good response at night. Some patients on James Ward told us that during the evening staffing numbers were very low, which sometimes resulted in patients waiting longer for care and treatment.

During our visit to the hospital we observed staff responding quickly to patients' requests for assistance.

Other evidence
Systems were in place to address unexpected staff shortages and thus ensure patients' needs were met. Bank and agency nurses were used to cover any staff shortages and when the needs of patients changed and more staff were needed.

Staff in Jack's Place considered there were enough paediatricians working in the evenings and weekends and they were able to provide a safe level of care to children. We were told this had improved after changes were made to services so that medical staff no longer had to cover paediatric services at Central Middlesex Hospital as well.
On average 270 patients were seen each day in A&E. In June this had risen to 300. Waiting times for ambulance handover of patients to A&E had improved. In April 2011 the one hour waiting time had been breached 20 times whereas in July there were no breaches at all. Staff told us that delays had been caused by difficulty in finding beds in the hospital to admit A&E patients to. On the day of our visit we did not see anyone waiting on a trolley to be seen.

Ward staff told us that during the day the shifts were ‘well staffed’. This was generally the same at night although some staff said that an additional healthcare assistant at night would be helpful. Staff told us that staff to patient ratios had improved and this ensured that patients’ needs would be met. The skill mix of staff on the wards was described as, ‘about right’. Some staff told us they were ‘very busy’ but staffing levels were such that patient safety was maintained.

Nurses told us that there were generally enough doctors available at night if they needed one to come to the ward. On Dickens Ward we were told it was never difficult to get a doctor as night as they were based there.

**Our judgement**

When the needs of patients changed procedures were in place to enable extra staff to be brought in. There were sufficient numbers of suitably qualified staff on duty to ensure patient's safety and meet their needs.

Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 14: Supporting staff

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

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

What we found

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

Our findings

What people who use the service experienced and told us
Patients and relatives told us that they felt confident in the skills of doctors and nurses and in their ability to provide competent care and treatment. For instance, a patient on Hardy Ward told us that the nurses were, ‘good at everything’ and fitted his feed professionally and safely.

Other evidence
Staff we spoke to had undertaken regular training in skills and areas relevant to their professional role. Nurses had undergone mandatory training which included fire safety, manual handling and infection control. Staff said that seeking additional training was supported and encouraged by their managers. In addition we saw a notice advertising upcoming training opportunities for staff, including safeguarding training, displayed in a staff room on one ward.

Generally staff said they felt supported by and listened to by their managers. One staff member, however, told us they had experienced unpleasant and racist comments from a patient and had not felt particularly supported by managers at the time.

All staff said they had received an annual performance appraisal in the last year. The frequency of formal clinical supervision provided to staff varied considerably. Some staff said they received clinical supervision on a monthly basis whilst others said they did not receive formal supervision between appraisals. They could, however, approach their manager at any time for support.

Newly qualified staff had a six month period of support from an experienced mentor.
They were given a book of clinical competencies which they needed to achieve. The achievement of these skills were verified by their mentor and recorded.

The staff we spoke to described good teamwork involving members of the multidisciplinary team. Staff on the paediatric ward attended two team away-days each year. On other wards staff meetings took place every few months.

**Our judgement**
Staff were supported to perform their role effectively and had undertaken training in areas relevant to their professional role and development. Patient's needs were met by competent staff.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 16:
Assessing and monitoring the quality of service provision

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

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement
The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
When we asked patients what they thought about the quality of service provided to them in the hospital they were all very positive. Some typical comments we received were: 'I am fortunate to be here' and one patient described their experience in the hospital as 'amazing'. One patient in A&E said the service was, 'pretty good'. Several people were pleased with the standards of cleanliness provided. For example, one patient said, 'all the beds were raised and they cleaned the window sills, lockers, tables and chairs'.

Other evidence
Staff told us that a number of quality audits took place on the wards, for example, in relation to infection control, pharmacy and nutrition. Staff confirmed that they received feedback from these.

Staff told us they reported all incidents related to patient safety on an electronic system. However, some staff said they did not always get feedback on these and were not sure that it was worth taking the time to fill in reports. Other staff were able to give us examples of changes made in practice in response to incidents and near misses. A safety and incident report was presented to the Trust Board in August 2011. This contained information on all serious incidents that had occurred in the previous 14 months, root causes of the incidents and actions taken. All staff told us that they would feel able to raise any concerns about patient care with their manager.

The Trust monitored complaints, litigation, incidents and Patient Advice and Liaison
Service (PALS) issues on a quarterly basis. Themes and trends were identified as well as learning and any changes required. Actions were subsequently taken to improve the services provided.

The Trust Board regularly reviewed performance against quality and risk key indicators. The Trust's performance was also benchmarked against that of other similar organisations.

The Trust's 'Quality Account 2010-2011' outlined the quality priorities for the Trust as well as demonstrating performance against a range of measures including clinical safety, national targets and patient experience indicators. Where shortfalls were identified the Trust had put in place action plans to address these.

The Trust carried out an annual patient satisfaction survey and the results and feedback from patients were used to improve services. We saw that suggestion boxes were placed beside the reception in A&E and on the wards aimed at gaining feedback from patients and relatives.

**Our judgement**
The quality of service provided to patients was monitored regularly. There was evidence of learning and changes in practice in response to analysis of complaints and incidents. Risks to patient safety were managed effectively.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 17: Complaints

What the outcome says
This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement
The provider is compliant with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
We asked patients whether they had made a complaint during their stay or how they would go about raising concerns if they wanted to.

A patient gave us an example of requesting to be moved due to noise levels in bays close by and told us that staff had dealt with this immediately and offered them an alternative bay. Another patient told us that she had complained about the food not being warm and the attitude from the catering staff towards her. She said that this has been dealt with satisfactorily and she had received an apology from the Trust.

Some patients said they had seen complaints leaflets on the ward although others had not. One patient said they had heard of the Patient Advice and Liaison Service (PALS) and seen a suggestion box on the ward.

Most patients we spoke said they did not have any complaints but said they would speak to matron, the ward sister or ward manager if they did have concerns. Patients were confident that if they raised any concerns they would be dealt with by staff.

Other evidence
The provision of information on complaints varied from ward to ward. For example, on Fielding Ward there was a notice beside the entrance to the ward telling people to inform staff if they had any concerns and there was information on display about PALS. Information on how to contact PALS was also available on Hardy Ward in leaflet holders. There was large notice displayed on James Ward giving the contact details for
PALS and another said, 'Are we getting it right – how you can be heard.'

However, on Jack's Place we did not see any leaflets available. Neither did we see information on the complaints procedure on display in A&E or Evelyn Ward. The receptionist in Evelyn confirmed that there were no leaflets available to give out.

All the wards we visited had a comments box available for patients to post their feedback.

Staff told us that they would try to deal with patients' or relatives' concerns as they arose or refer them to PALS if they needed more support. The Trust monitored complaints and PALS issues on a quarterly basis and improvements in service delivery were made as a result (see outcome 16 for more detail).

Patient representatives from the Trust Patient and Public Involvement Forum reviewed the documentation from 24 complaints which were reopened during the period 1 April 2010 to 31 March 2011 and gave feedback on the responses to complaints. They looked at whether the original complaints had been addressed, the tone of response and the ease of reading the response. They also made suggestions as to how responses to complaints could be improved. This demonstrated that the Trust was trying to improve the way it handled and responded to complaints.

**Our judgement**

Although information on how to complain was not clearly displayed on all wards and departments, patients felt able to raise issues of concern with staff and were confident they would be dealt with. Learning had taken place and changes made in service delivery in response to complaints. Overall, we found that Northwick Park Hospital was meeting this essential standard.
Outcome 21: Records

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

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement
The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to patients about this outcome area.

Other evidence
We reviewed a number of patient healthcare records on all the wards we visited. The records were legible, signed and dated. They all contained detailed information in relation to the care and treatment of the patient. There were completed copies of a number of assessment forms including the pain assessments, nutrition and pressure area risk assessments. Comfort round charts were mostly completed showing that patients had been checked by staff at least every two hours.

However, how decisions were reached in relation to whether to attempt to resuscitate patients was not always fully documented (see outcome 2 for more detail).

There was evidence of multidisciplinary involvement in the care and treatment of patients and referrals made to other services. Records were held securely and we observed staff placing records in a safe place when not in use. The staff we spoke to all understood the importance of maintaining patient confidentiality.

Our judgement
Health care records were stored securely. Generally they were accurate and contained detailed information relevant to patients’ care and treatment.
Overall, we found that Northwick Park Hospital was meeting this essential standard.
## Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 02: Consent to care and treatment</td>
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<tr>
<td></td>
<td><strong>Why we have concerns:</strong></td>
<td></td>
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<tr>
<td></td>
<td>Generally care and treatment were explained to people in a way in which they understood and suitable arrangements were in place for obtaining valid consent. However, in some instances documentation in relation to decisions not to attempt resuscitation of patients was incomplete. It was not clear whether patients or their relatives had been consulted on the decision taken.</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 09: Management of medicines</td>
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<tr>
<td></td>
<td><strong>Why we have concerns:</strong></td>
<td></td>
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<td></td>
<td>Patients were provided with information on the medication prescribed for them. Generally patients were protected against the risks associated with the unsafe use and management of medicines. However, not all medication had been stored safely in paediatrics. Expired medication was found in a drugs fridge and fridge temperatures were not monitored consistently on all wards. As a result patients could have been put at risk of receiving ineffective medication.</td>
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The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
The provider’s report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.
What is a review of compliance?

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

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

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

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

<table>
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<tr>
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<th>Review of compliance report</th>
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<td>Author</td>
<td>Care Quality Commission</td>
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