Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Betsi Cadwaladr University Health Board / Ysbyty Gwynedd / Maternity Services

Inspection date: 30 and 31 January 2018

Publication date: 2 May 2018

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Digital ISBN 978-1-78903-765-4

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Maternity services within Betsi Cadwaladr University Health Board on 30 and 31 January 2018. The following hospital site and wards were visited during this inspection:

Ysbyty Gwynedd

- Llifon
- Labour ward
- Midwife led unit

Our team, for the inspection comprised of two HIW Inspectors (one of whom led the inspection) and two clinical peer reviewers.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We were satisfied that Llifon, Labour and the Midwife led unit provided safe and effective care, which met with the Health and Care Standards (April 2015).

Patients were satisfied with the care they received and spoke highly regarding the professional, courteous and supportive attitudes of the staff.

Staff of all grades were receptive to the inspection process and were open and transparent in their discussions.

There was a great deal of emphasis on promoting innovative, forward thinking care.

Although we highlighted some areas of improvement which would enhance the good service already being provided, we also saw evidence of a number of areas where there was noteworthy practice.

Overall, the midwifery service at Ysbyty Gwynedd was excelling in their attempt to offer a comparable service to that of a large inner city unit.

This is what we found the service did well:

- Patients were treated with dignity and respect
- The environment on the wards was well maintained and uncluttered
- Arrangements were in place for patients and their families to give feedback on their experiences
- We found systems were in place with the aim of protecting patients from avoidable harm and to keep them safe
- Staff had assessed patients' needs and developed written plans to meet these needs
- Arrangements were in place for the safe management of medicines
- We found good leadership and direction provided by senior staff, with systems in place to monitor the effectiveness and safety of services provided

- Staff presented as professional and knowledgeable, with numbers and skill mix within the staff team, on the days of inspection, appearing appropriate to meet the needs of patients

This is what we recommend the service could improve:

- Development of a point of contact for bereaved families
- Ensure that staff have access to all relative/ sensitive information regarding patients in their care
- Recording of daily checks
- Improved access to scanning for mothers with fetal growth concerns

3. What we found

Background of the service

Betsi Cadwaladr University Health Board is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services for a population of around 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham).

There are three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital) along with a network of community hospitals, health centres, clinics, mental health units and community team bases. The Health Board also coordinates the work of 109 GP practices and NHS services provided by dentists, opticians and pharmacists in North Wales.

The maternity service at Ysbyty Gwynedd consists of a delivery suite made up of eight labour rooms, one having a plumbed in birth pool. Alongside this, there is a Midwife Led Unit (MLU) which has two birthing rooms, one of which also has a plumbed in birthing pool. After delivery, the hospital has a post natal ward should the mother require a longer stay in hospital. There is a special care baby unit at the hospital which works closely with the central special baby care unit at Ysbyty Glan Clwyd.

During our visit there was one patient on the Midwife Led Unit but we did not get the opportunity to speak with her.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We found that patients were treated with dignity and respect whilst on the wards. This is because we observed staff being compassionate and protecting the privacy and dignity of patients and their families.

Information was available to patients via a variety of means and they told us staff had spoken to them about their care and treatment in a way they could understand.

The environments on the wards were well maintained and generally uncluttered.

Arrangements were in place for patients and their families to give feedback on their experiences and these were used to learn and improve patients' experience.

During the inspection we distributed HIW questionnaires to patients on both LLifon and the Labour ward to obtain their views on the services provided. A total of 11 were completed and returned. We also spoke to a number of patients during the inspection.

Feedback provided by patients in the questionnaires was positive; they rated the care and treatment provided during their stay in hospital as nine out of ten, and all patients agreed that staff were kind and sensitive when carrying out care and treatment.

Staying healthy

We saw that information leaflets for patients and their carers were readily available in both English and Welsh. These included leaflets about smoking cessation, protecting women and babies, pregnancy and nutrition, healthy eating and safe parenting. Additionally there was information on services provided by the health board such as wound care and post natal information checks. There was also a lead midwife for mental health available for advice and support.

Dignified care

Patients were asked in the questionnaires whether they agreed or disagreed with a number of statements about the hospital staff. All patients agreed that staff were always polite and listened, both to them and to their friends and family. All patients told us that staff called them by their preferred name.

Partners told us that they were made to feel welcome and we were shown a patients/relatives kitchen area where teas and coffees could be made.

The MLU had individual rooms with en-suite facilities; there were individual rooms in the labour ward with no en suite facilities and there was a mixture of single rooms and small bays in Llifon with both ensuite and shared bathing facilities.

We discussed with patients and staff regarding the importance of “skin to skin” practice[1] for the physical and psychological care of both parent and child. We were told that staff on the ward promoted this as best practice.

Sensitive support was offered at a difficult time, when parents were grieving the death of a baby. The ward had a private room with sleeping arrangements and fairly comfortable surroundings, where parents could spend as much time as they required with their baby, whilst grieving their loss. This room would benefit from some redecoration. There wasn't a bereavement midwife to support parents through this difficult time, although all midwives are trained to deal with tragic circumstances and staff would refer to voluntary organisations. Discussion with the ward manager indicated that there was a member of staff who was interested in developing this role.

Patients who required emergency surgical intervention (caesarean section) were transferred to theatres which were conveniently situated near to the unit.

We were told by most of the staff that patient’s privacy and dignity is always maintained, that patient independence is always promoted and that patients

[1] Skin-to-skin contact with babies soon after birth has been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation. (www.nice.org.uk).

and/or their relatives are involved in decisions about their care. This was confirmed in our conversations with patients and their families.

One patient told us about an incident that had occurred during the weekend prior to our inspection, (where a doctor had not maintained the patients dignity and respect). This was dealt with by means of a letter to the Chief Executive and the Medical Director. HIW received a satisfactory response on the 12 March 2018.

Improvement needed

It would be beneficial to some parents if the health board could explore the development of a bereavement midwife

Angel Room (the bereavement room) would benefit from some redecoration.

Patient information

We saw some information leaflets for patients to read on the wall of the ward and there was also an information board in the corridor. However it would be beneficial if there was a designated member of staff to ensure that all information leaflets are always available.

There was a fully staffed assessment unit which patients could access for information, examination or general advice. This unit was available 24 hours a day all week. This was an example of noteworthy practice.

Communicating effectively

The majority of patients confirmed in the questionnaires that they were offered the option to communicate with staff in the language of their choice.

Patients also told us that they were able to speak with staff in Welsh or English and we were given an example where staff had spoken in Welsh to the baby as soon as it was born, reinforcing the chosen language of the family unit.

There was a loop system for patients with hearing difficulties and we were told that staff used photographic communication tools for patients with ethnic minority languages or complicated communication issues.

The labour ward has a Patient Safety at a Glance Board which is not visible to visitors.

An enthusiastic, motivated and knowledgeable consultant midwife was employed to; improve communication between midwifery and obstetric staff

teams across the health board; improve community care and to promote patient involvement. This role is relatively new, however it has effected many changes across all three maternity sites within the health board; with the development of improved team working in individual hospitals, development of the maternity patient voices and involvement in the "Your birth we care" All Wales survey.[2].

Timely care

Only one patient said in the questionnaires that they didn't always have access to a buzzer; the majority of patients agreed that staff came to them when they used the buzzer.

We found that staff were regularly evaluating patients' progress in labour and the after care with baby, with the aim of ensuring that their individual care needs, wishes and preferences were being met. Patients told us that there was very good support to encourage breast feeding, which was offered in a calm, respectful and reassuring manner.

Individual care

Planning care to promote independence

Patients and their partners told us that they were fully involved in all the decisions regarding the birth and the immediate after care of their baby. We saw that both the labour ward and the MLU offered birthing pools, which was another area of noteworthy practice. This gave the opportunity for patients with health complications, who could not always access the MLU, to also experience a water birth if they wished.

Listening and learning from feedback

Each staff member spoken with knew that patient experience feedback (e.g. patient surveys, suggestion box on the wards) was collected within their directorate or department. Staff members also said that they received regular

[2] The Consultant midwife group for Wales is conducting a survey to evaluate women's views of antenatal services and how current service provision prepares women for labour and birth

updates on the patient experience feedback and felt that it is used to make informed decisions within their directorate or department.

The health board were pro-active in listening to patients and had established a maternity patient's voices forum. There was also a conference planned for March (arranged by the consultant midwife) to give credence and a platform for patient's views to be heard. This was an example of noteworthy practice.

Senior staff explained that, wherever possible, staff would try and resolve concerns raised by patients or their representatives at ward level. Where this could not be achieved they were aware of the escalation process to follow so that concerns (complaints) may be considered under the Putting Things Right[3] arrangements. However, discussion with patients indicated that they were not aware of the Putting Things Right process. This information needs to be made available to patients on their arrival.

Staff told us that they have seen errors, near misses or incidents in the last month that could have hurt staff or patients and generally agreed that their organisation encourages them to report errors, near misses or incidents, and agreed that when they are reported, the organisation would take action to ensure that they do not happen again.

Although staff were undecided about whether the organisation treats staff who are involved in an error, near miss or incident, fairly, and with adequate support, they did feel that the organisation would treat any error, near miss or incident that is reported confidentially.

We were, however, informed that any errors, near misses or incidents that happen in the organisation are fedback and changes made in response to such incidents.

[3] *Putting Things Right* are the arrangements for managing concerns (complaints) about NHS care and treatment in Wales.

Improvement needed

The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident.

The ward managers need to ensure that the Putting Things Right information is made available to patients in a timely manner..

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We were satisfied that we saw safe and effective care being delivered by competent, efficient and caring staff; who were passionate about their work. There was a commitment for the maternity process to be as normal as possible.

We found systems were in place with the aim of protecting patients from avoidable harm and to keep them safe. This included an exemplar of emergency drills. All the clinical areas we visited were clean and free from obvious hazards.

Staff had assessed patients' needs and developed written plans to meet these needs. All patient notes, that we looked at, were clear and well documented.

Arrangements were in place for the safe management of medicines.

Safe care

Managing risk and promoting health and safety

There were arrangements in place to maintain the safety of patients and staff in the areas we visited. For example, entry to the ward was gained via an intercom system. We observed staff politely asking visitors the reason for their visit before allowing them to proceed. We did not identify any obvious environmental hazards during our inspection.

There was a mixture of single rooms and small bays and we saw that patients' privacy was protected by closing doors or drawing privacy curtains. Staff told us that patients' individual needs were assessed on admission and if this identified a single cubicle was needed; arrangements would be made for this wherever possible.

We saw that relevant risk assessments had been completed as part of the patient admission process to hospital.

We discussed the management and processes for safe practice whilst caring for neonatal babies at the hospital. We were assured that systems were in

place to reduce the probability of delivering a baby who may need the service by the early referral, to Ysbyty Glan Clwyd. However there was a Special Care Baby Unit on site which could support new born babies until they were transferred to the central specialist unit in Ysbyty Glan Clwyd. However, in an emergency situation staff explained that all midwives were trained to care for neonatal babies and in house training was undertaken regularly as part of the "skills and drills" training. We were also told about the excellent PROMPTS[4] and OMPS[5] emergency drills which staff regularly undertook. We had no concerns regarding the specialist care provided in the units.

We discussed areas of improvement with staff and were told that one area for development was to improve access to scanning for patients with foetal growth concerns. This we were told is an issue with the Radiography department and as such is out of the control of the maternity unit. However we discussed this with the Director of Midwifery and Women's Directorate as a possible way forward for the health board.

Infection prevention and control

All the clinical areas we visited were very clean and tidy. Comments received via completed HIW questionnaires and face to face interviews also confirmed this. All areas had arrangements in place to reduce cross infection.

With the exception of one domestic member of staff, we saw that staff had access to, and were using, personal protective equipment (PPE) such as disposable gloves and aprons to reduce cross infection. We spoke to the individual member of staff immediately and questioned regarding the lack of use of protective aprons and were disappointed to see later that this had not been corrected. We spoke to senior staff regarding this issue to ensure it was not a culture within staff teams. We were assured that this was not the case and that the incident would be addressed by the domestic team leader.

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[4] PROMPT (Practical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working

[5] OMPS (Obstetric Midwifery Practical Skills) is practical skills training for midwives to maintain their competencies in specific areas of midwifery.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. We also saw hand sanitising stations strategically placed near entrances/exits and around clinical areas for staff and visitors to use.

We also found that procedures were in place within each area to check and clean equipment to ensure this was safe to use and reduce the spread of infection.

Staff we spoke to confirmed they had access to the health board's policies and procedures on infection control within the clinical areas where they worked. Staff also confirmed they had attended training on infection control within the last 12 months. We saw that regular audits had been completed in respect of infection control within the clinical areas we visited.

The maternity unit also offered optional screening for patients at 32-34 weeks gestation for infections such as MRSA.[6] This is another area of noteworthy practice.

Additionally arrangements are made for any discharged maternity patient who has an infection to be reviewed at the assessment unit. Patients are seen by a full team where information and ongoing treatment is offered. At present the unit sees about three patients a month. This is again an area of noteworthy practice.

Nutrition and hydration

All patients that completed a questionnaire told us that they had time to eat their food at their own pace and that water was always accessible.

Medicines management

Overall, we found arrangements in place for the safe management of medicines used in the clinical areas we visited.

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[6] Methicillin Resistant Staphylococcus Aureus is a bacterial infection that can be resistant to treatment with many common antibiotics.

We saw that most medicines were being correctly and securely stored. However some medicines that required refrigeration were not stored in a locked refrigerator neither was the refrigerator temperature being checked and monitored daily to ensure the optimum temperature was maintained for the storage of refrigerated medicines. Although the door to the medication room was supposed to be locked, it was not at the time of inspection and therefore the drugs in the fridge were easily accessible.

We looked at a sample of medication records and saw these had been completed correctly. We found safe practice in respect of the administration of medicines.

Records had been maintained of the amounts of controlled drugs held and administered in all areas inspected.

We asked to see the medicine management policy and staff were initially unable to find the document on the intranet system. We were then advised that the policy available was an old policy. The health board needs to ensure that current policies and old policies are stored separately and that clinical staff do not have access to historical policies.

Improvement needed

The ward manager needs to ensure that the medicine refrigerator is locked, the door kept closed when not is use and fridge temperature readings are recorded daily

The health board needs to explore the timely access to scanning for patients with foetal growth concerns

The health board needs to ensure clinical staff only have access to current policies.

Safeguarding children and adults at risk

As described earlier, security measures were in place to protect patients within the ward/units. Conversations with staff indicated they had a good understanding of safeguarding processes to protect the welfare and safety of patients and children who may be at risk.

Staff had access to a safeguarding lead who could provide advice and support on safeguarding issues. However, we were told, when patients were admitted as an emergency and may have identified safeguarding concerns, staff would not always have the information available immediately and would need to wait

until the patients hospital notes were delivered to the unit. This posed a potential risk to both patient and baby. Before the inspection was concluded the Labour ward had developed a system whereby this information was available and stored in a safe place and could be accessed at any time.

All babies are tagged and monitored electronically in the delivery room. On transfer to Llifon ward the tag is suspended for 15 minutes but staff remain with the baby at all times. Abduction drills are performed periodically to ensure staff are aware of the requirements on them. All doors to the labour ward automatically lock if a tag is activated. We observed an incident where the tag was accidentally activated and saw the staff respond in a timely, calm and appropriate manner.

Medical devices, equipment and diagnostic systems

We saw that a range of medical and nursing equipment was available which was visibly clean and appeared well maintained.

Staff explained that they regularly checked equipment and we saw written logbooks to support the process described. Written policies were in place to guide staff on the correct cleaning and decontamination of cots and incubators.

We saw the compact and discrete neo-natal resuscitaire[7] which was on the wall of every delivery room. They were modern and slim line so were unobtrusive in the room with the patient. However when we looked at the cleaning and checking schedules they were not checked daily. This equipment needs to be checked and recorded daily to ensure all areas are in good working order in the case of an emergency.

We saw the use of upright furniture in some delivery rooms. These were modern and offered alternatives to beds for patients.

We checked the blood monitoring machine and found that the solution was out of date. When we told staff it was discarded and renewed immediately.[8]

[7] Resuscitaire is specialist equipment needed for a clinical emergency and resuscitation.

[8]

Improvement needed

The resuscitaires need to have daily cleaning and checking schedules in place.

Effective care

Safe and clinically effective care

We found many examples of innovative and noteworthy practice within the maternity units of Ysbyty Gwynedd. Staff explained that with the new management structure and the changes in leadership, patient care had become more evidence based and care could be tailored to meet the needs of the individual patient. This was made possible with the open and proactive management style.

The majority of staff stated that they felt they were generally satisfied with the quality of care they are able to give to patients. They told us they were clear on processes if they were concerned about unsafe clinical practice. Additionally they felt secure raising concerns, confident that their organisation would address their concerns once reported.

Quality improvement, research and innovation

Staff had excellent access to learning opportunities for their continuing professional development. The simulated multi disciplinary training was exemplary. The health board had a commitment to ensuring staff were well trained allowing four days a year for training.

We have identified numerous areas of noteworthy practice throughout this report.

The maternity services were currently in the consultation process for changing working hours to enable community and hospital staff to work more effectively together. All staff were unsure that this was a positive step forward; however discussion with senior staff and the consultant midwife clarified the long term benefits to both staff and patients.

We were told that "listening groups" had been developed in the community and an area identified for improvement was more help for new mothers who are breastfeeding when they are first discharged home.

We were also told that the health board were promoting the "Gap and Grow" initiative and had reduced the incidents of stillborn babies by 50% across the health board, despite the problems with the radiographic department regarding access to foetal scanning.

Information governance and communications technology

At present Ysbyty Gwynedd is not fully established on the health board electronic system. The proposed system change will be completed this year (2018).

Record keeping

Overall we found patient records had been well maintained were clear and completed in a timely manner.

We considered a sample of patient records (two on Llifon and three on the Labour ward). We found regular written entries had been made within patients' notes, which effectively demonstrated a multi disciplinary approach to patient care. We did see that there were omissions in some areas of the All Wales normal labour pathway on the labour ward; however this would not have impacted on standards of care. On Llifon ward we saw that, although some patient notes were difficult to navigate with miscellaneous information filed within the patient's notes, generally they were of a good standard.

We were told that in both the MLU and Llifon ward medication charts and nursing documentation were stored together, however on the labour ward the medication administration charts were stored separately. It would be beneficial if all wards maintained the same ways of working.

We found patient records were being stored securely when not in use to prevent access by unauthorised persons.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

We found good, visible, leadership and direction provided by senior staff on the wards. Systems were in place to monitor the effectiveness and safety of services provided.

Staff presented as professional and knowledgeable, with numbers and skill mix within staff teams appearing appropriate, on the day of inspection, to meet the needs of patients.

Staff confirmed they had very good access to training opportunities relevant to their role.

The responses given by staff in the questionnaires suggested that some staff members had personally experienced discrimination at work from their manager, team leader or other colleagues.

Governance, leadership and accountability

During our inspection we distributed HIW questionnaires to staff working on the wards to find out what the working conditions were like, and to understand their views on the quality of the maternity services provided to patients at the hospital.

In total, we received 11 completed questionnaires from staff undertaking a range of roles on the units. Staff had worked at the hospital ranging from a few months to more than 15 years. These findings contribute to the body of this section.

The inspectors found good, visible, leadership and direction provided by senior staff on the ward. There was a pro-active management approach to care, with clear lines of accountability and responsibility. Systems were described as being in place to monitor the effectiveness and safety of services provided.

These included local audits associated with patient care and staffing to monitor compliance with health board standards and processes. Audits were also completed with regard to concerns (complaints) and patient safety incidents with a view to ensuring that staff were supported to improve their practice wherever possible and make improvements to the provision of service as appropriate. Staff confirmed that the health board had access to the right information to monitor the quality of care across all clinical interventions and to take swift action when there were shortcomings. They said there was always a culture of openness and learning with the health board that supported staff to identify and solve problems.

Although staff felt they were not always consulted regarding departmental changes, they confirmed that management were always supportive, and that front line professionals who dealt with patients were always empowered to speak up and take action when issues arose in line with the requirements of their own professional conduct and competence.

All staff members agreed that their manager always encouraged team working and were supportive in a personal crisis. They confirmed that they were always given clear feedback on their work and were asked for their opinions before decisions were made that directly affected their work. They felt that managers could always be counted on to help them with a difficult task at work. One comment was;

> *"Recent change in Senior Management; feel more supported and have seen a vast improvement in communication between Senior Managers and staff"*

Most of the staff that completed a questionnaire felt that their organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Staff and resources

Workforce

Although staff indicated in the questionnaires that they were only sometimes able to meet all the conflicting demands on their time at work, and that there were only sometimes enough staff at the organisation to enable them to do their job properly; we found on the days of inspection that staff presented as professional and knowledgeable, with numbers and skill mix within the staff team appearing appropriate to meet the needs of patients.

Staff told us that they were able to call upon the community midwives for support if they were not busy with their own patients and senior staff indicated that they had reduced the agency coverage from 55% to 8% which is commendable, although there continues to be a higher than average sickness in the midwifery directorate.

Senior staff explained the health board had an escalation policy which was to be implemented in the event of a staff shortfall and/or increased patient dependency. For example the units had four hourly acuity checks to ensure there were enough staff to meet the patient's needs.

All staff who returned questionnaires indicated they had attended training (including taught courses and learning through on-the-job training or shadowing) within the last 12 months on topics such as; health and safety, fire safety and infection control. Most indicated they had also attended training in relation to the speciality of care in their clinical area. We saw information displayed within the clinical area on a range of relevant training sessions available to staff. We were satisfied that the staff team had access to and were more than adequately supported to attend learning opportunities and to undertake emergency drill training.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
The blood glucose monitoring solution was found to be out of the manufacturers recommended use by date.	This meant that patients requiring blood glucose monitoring may not have received accurate readings.	We raised this concern with ward staff during the inspection and requested this was immediately resolved.	Ward staff disposed of the solution in the blood monitoring box and replaced with a new solution bottle.

Appendix B – Immediate improvement plan

Hospital: Ysbyty Gwynedd

Ward/department: MLU/Labour/Llifon ward

Date of inspection: 30 and 31 January 2018

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
There were no immediate assurance improvements identified on this occasion.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Ysbyty Gwynedd

Ward/department: MLU/Labour/Llifon ward

Date of inspection: 30 and 31 January 2018

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
It would be beneficial to some parents if the health board could explore the development of a bereavement midwife Angel Room (the bereavement room) would benefit from some redecoration.	4.1 Dignified Care	• Job Description for the post of a Bereavement Midwife for the Women's Directorate in BCUHB is in the process of being developed. • Aim is to recruit to a full time Bereavement Midwife post by July 2018.	Head of Women's Inpatient and Outpatient Services Head of Women's Inpatient and Outpatient Services	July 2018 July 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Meeting held with SANDS Local Representatives on the 26.3.18 to discuss re-decoration of the Angel Room. • Plan to re-decorate in the next 3 months in partnership with the local SANDS Groups.	Head of Women's Inpatient and Outpatient Services Head of Women's Inpatient and Outpatient Services	March 2018 **Completed** **July 2018**
The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident.	6.3 Listening and Learning from feedback	• Clinical Supervisors of Midwifery to explore with staff what levels of support would be beneficial. • Unit meetings held bi monthly to include opportunity for staff to highlight any concerns, and post incident support they need going forward. Meeting dates issued 12 months in advance.	Clinical Supervisor of Midwives Inpatient Matrons	Commencing April 2018 March 2018 **Completed**

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Open door policy adopted by all managers within the unit and staff aware that they can access this support and guidance at any time. Reiterated at all site meetings in March 2018 and during Staff Drop In Sessions.	Inpatient Matrons	March 2018 **Completed**
		• Lessons learned are cascaded to all staff in a timely manner following all incidents.	Inpatient Matrons	March 2018 **Completed**
		• Clinical Supervisor for Midwives (CSfM) always available to support staff in an open and confidential manner offering support and guidance, as part of their role.	Clinical Supervisor of Midwives	**Completed** (ongoing practice**)**
		• All midwives receive 4hrs mandatory contact with CSfM – on an annual basis which includes 2hrs group supervision and 2hrs for local learning to inform practice.	Clinical Supervisor of Midwives	Ongoing Practice

Improvement needed	Standard	Service action	Responsible officer	Timescale
The ward managers need to ensure that the Putting Things Right information is made available to patients in a timely manner.		• Putting things right information is made available to all patients in the booking information given out by the community midwife during the antenatal period, to ensure that patients receive the information in a timely manner. • PTR Leaflets are displayed and available in all Inpatient Areas.	Women's Directorate Inpatient and Outpatient Matrons Women's Inpatient Ward Managers	April 2018 **Completed** April 2018 **Completed**
Delivery of safe and effective care				
The health board needs to explore the timely access to scanning for patients with foetal growth concerns	2.1 Managing risk and promoting health and safety	• Discussions with Shared Services that manage USS provision and capacity in the Health Board have commenced and will continue to work through solutions. • Further meeting scheduled with the Head of Shared Services in April 2018.	General Manager General Manager	September 2018 April 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board needs to ensure clinical staff only have access to current policies.		• USS capacity is highlighted on the Women's Directorate risk register as an open risk for services to manage and support demand and capacity. • An icon to Access all Written Control Documents has been placed on IT desk-tops on all departmental computers in clinical areas. • How to Access Health Board Policies has been included in the ward safety briefings for a 2 week period in February 2018. • Clinical Supervisors for Midwives are also reminding midwives of how to access policies during their clinical supervision updates. • Work is progressing pan BCUHB to ensure that all duplicate or out of date policies are removed from the Intranet.	General Manager Inpatient Managers Ward Managers /Shift leaders Clinical Supervisors of Midwives Transforming care team	Review May 2018 February 2018 **Completed** February 2018 **Completed** Ongoing Practice September 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The ward manager needs to ensure that the medicine refrigerator is locked, the door kept closed when not is use and fridge temperature readings are recorded daily	2.6 Medicines Management	• All fridges have locks and daily checks are conducted to ensure temperatures are recorded. • A new system has been introduced to ensure all daily checks required are highlighted in the one file for ease of access and signed off by the shift leader on that day – this is then checked for compliance by the ward managers. • Safe storage of medication and daily checking of the medicines fridge temperature has been included on the Matron's daily intentional rounding and quality assurance form (Version 11 February 2018). • The quality assurance form is completed on a monthly basis by	Ward Managers Shift Leaders/Ward Managers Inpatient Matrons Inpatient Matrons	February 2018 **Completed** February 2018 **Completed** (Monitored on a monthly basis) Daily as of February 2018 **Completed/ Ongoing** Monthly as of February

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the matron and compliance reported together with any themes and trends to the Women's Quality, Safety and Experience Group on a monthly basis.		2018 **Completed**
The resuscitaires need to have daily cleaning and checking schedules in place.	2.9 Medical devices, equipment and diagnostic systems	• Checks are completed daily. • Daily checking of the resusitaires on the Delivery Suites, Midwifery led units and maternity wards are included on the Matron's daily intentional rounding and quality assurance form (version 11 February 2018). • The quality assurance form is completed on a monthly basis by the Matrons and the compliance reported together with any	Ward Manager/Shift Leaders Inpatient Matrons Inpatient Matrons	February 2018 **Completed** (Monitored on a monthly basis). February 2018 **Completed** (ongoing practice) Monthly as of February 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		themes and trends to the Women's Quality, Safety and Experience Group on a monthly basis.		**Completed**
Quality of management and leadership				
There were no improvements identified on this occasion.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Fiona Gwynedd Giraud

Job role: Director of Midwifery & Women's Directorate

Date: 01/04/18