Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Bronglais General Hospital / Maternity Services – Gwenllian Ward and Midwifery Led Unit

Hywel Dda University Health Board

Inspection date: 21, 22 and 23 October 2019

Publication date: 24 January 2020

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-83933-896-0

Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 Bronglais Hospital within Hywel Dda University Health Board on the 21, 22 and 23 October 2019. This inspection is part of HIW's national review of maternity services across Wales.[1]

The following hospital wards were visited during this inspection:

- Gwenllian Ward
- Midwifery Led Unit.

Our team for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives) and one lay reviewer.

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.

[1] https://hiw.org.uk/national-review-maternity-services

Summary of our inspection

Overall, we found that the service provided care in a respectful and dignified way to patients.

However, we identified some improvements were required to ensure that the service was providing safe and effective care at all times.

This is what we found the service did well:

- Women and their families rated the care and treatment provided during their time on the unit as excellent
- We observed staff treating patients with warmth, respect and courtesy at all times and care was provided in a dignified way
- Patients were given an information pack at the time of their discharge which contained a variety of useful information
- A database to support the safeguarding of women and babies who may be at risk
- The midwifery team were cohesive and had a good relationship with senior managers.

This is what we recommend the service could improve:

- Checks on emergency equipment
- Regular baby abduction drills
- Updates to some of the midwifery and medical clinical policies and guidelines
- Quality of patient record keeping.

2. What we found

Background of the service

Bronglais Hospital is located in Aberystwyth and forms part of the health care services provided by Hywel Dda University Health Board (the health board). The health board provides healthcare services to a total population of around 384,000, throughout Carmarthenshire, Ceredigion and Pembrokeshire. It provides acute, primary, community, mental health and learning disabilities services. The health board covers a quarter of the landmass of Wales and is the second most sparsely populated health board area in Wales.

The largest hospitals within the health board are Bronglais Hospital, Glangwili Hospital and Withybush Hospital. The health board operates twelve other smaller hospitals. Bronglais Hospital is the only acute hospital serving the population of mid-Wales.

Maternity services are offered to all patients and their families living within the geographical boundary of the health board. Maternity services also provide care to patients who choose to birth in the health board facilities who reside outside the geographical boundary. The health board averages over 3,100 births per year with around 450 of these at Bronglais Hospital.

The choices available within the health board for place of birth include a homebirth, free-standing midwife unit, midwife led care at an alongside midwife unit and an obstetric unit.

Bronglais Hospital comprises of a low risk pregnancy obstetric led unit with a neonatal stabilisation facility[2].

A midwifery led unit is also located within Bronglais Hospital.

[2] A stabilisation unit is used for babies who require short term intensive care and stabilisation prior to being transferred to a special care baby unit.

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.

Patients were positive about their overall experience of the service and rated the care and treatment received during their stay at the maternity unit as excellent.

We observed staff treating patients with warmth, respect and courtesy at all times.

We found that the location of the bereavement room within the unit would be better placed away from other patient's rooms in the centre of the ward in order to support patient's privacy and dignity.

Smoking cessation advice was not readily available to patients.

We advised the health board to consider the information in the birth place decision leaflet to ensure patients have a full understanding of the services available at the unit.

We recommended improvements to the systems to provide staff with feedback from patients and their families.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided to patients. A total of five questionnaires were completed. We also spoke to some patients during the inspection.

All patients who completed questionnaires rated the care and treatment received during their stay at the maternity unit as excellent. All the patients we spoke to praised the staff for their care and attentiveness. Some of the patient comments included the following:

> *"Husband and two children came in last night and staff were lovely with them. Nothing is too much trouble for staff."*

"I am having some difficulty breastfeeding but midwife stayed for a long time last night and today to help me breastfeed."

"I have called them during the night for help and they have always responded and helped me. I have struggled with breastfeeding in the past."

Staying healthy

There was no smoking cessation information visible on the information boards on the ward. This information would promote the health of patients both during and after pregnancy. Smoking cessation leaflets were available within the visitor's room outside the ward; however, they were located out of sight and not easily accessible. We saw that smoking cessation advice is provided during antenatal appointments in the sample of patient records we reviewed.

We saw bilingual posters in the unit displaying contact details for breastfeeding support groups in local areas. We also saw a variety of information which included exercise classes such as yoga, counselling, and single parent groups.

We saw a plaque on the wall stating that the unit was UNICEF[3] baby friendly accredited in November 2018. Accreditation is reviewed every three years which confirms the unit's compliance with this.

Improvement needed

The health board must ensure that smoking cessation information is readily available throughout the unit.

Dignified care

[3] https://www.unicef.org.uk/babyfriendly/ - The Baby Friendly Initiative is transforming healthcare for babies, their mothers and families in the UK, as part of a wider global partnership between the World Health Organisation (WHO) and Unicef.

During our inspection, we witnessed many examples of staff being compassionate, kind and friendly to patients and their families. We observed staff treating patients with warmth, respect and courtesy at all times. All staff appeared dedicated and keen to give the best care they could to their patients.

Patients told us they felt secure and the staff were very caring. All patients who completed a questionnaire and those we spoke to agreed that staff were always polite and listened to them and to their friends and family. All of the patients agreed staff called them by their preferred name.

Staff were observed to provide care to patients in a dignified and private way. We saw that doors were closed and curtains drawn to ensure their privacy and dignity were maintained.

A room was available on the unit which would be used as a bereavement room in the event of an intrapartum death[4] or a stillbirth. We saw this room provided a suitable environment for patients and families to use. However, we considered that the location of the room within the unit would be better placed away from other patient's rooms in the centre of the ward in order to support privacy and dignity.

We were told the health board had a lead bereavement midwife but we were unable to speak to them during our inspection; however, we spoke to a midwife who acted as support to the lead bereavement midwife. They were based at the unit and had attended additional training specific to their role in supporting women who had experienced an intrapartum death or stillbirth. We saw that the midwife was very committed to her role and enthusiastic in improving care for patients. They told us they felt well supported in their role, both from colleagues and management.

All patients who completed questionnaires said they were given support about how they may feel emotionally after the birth.

[4] the death of a baby after the onset of labour but before they are born

Improvement needed

The health board should consider the location of the bereavement room on the ward to ensure the privacy and dignity of the patient and their partner/carer are maintained.

Patient information

We found that directions to the maternity unit were clearly displayed throughout the hospital. This made it easily accessible for people to locate the appropriate place to attend for care.

We saw a range of information was displayed for patients. The unit produced a bilingual monthly maternity newsletter for patients which included details of the number of babies born, their weight, sex and weight. These were located around the unit and were seen to be a positive way of conveying information to patients.

Daily staffing details of the unit were displayed near the nurse's station on the ward. This included staff names and colour coded tunics next to each staff member which reflected their designation. This was useful for patients and their families/carers in identifying who was on duty and caring for them.

Every patient was given an information pack at the time of their discharge from the unit. We found the pack to contain useful information for patients which included advice on breastfeeding and formula feeding, how to register the birth, pelvic floor exercises and contraception.

Communicating effectively

Staff we spoke to were aware of the translation services within the health board and how they were able to access these. All patients who completed a questionnaire agreed they were offered the option to communicate with staff in the language of their choice.

All patients were positive about their interactions with staff during their time on the unit. All those who completed a questionnaire agreed that staff had explained their birth options and any risks related to their pregnancy and the support they had been offered.

Most patients who completed questionnaires said they were offered a choice about where to have their baby. All of the women we spoke to said they were given choice about where to have their baby including a home birth.

We saw that staff maintained patient privacy when communicating information within the unit. Every patient we spoke to were in their own private room within the unit. This meant they could communicate sensitive information to their families and staff in private without being overheard.

A Facebook social media page had been created to electronically communicate information to patients. This provided support for pregnant women and new mums. We were also told by staff that the maternity liaison group had been re-established to identify what local patients want and need from maternity services and to help to develop services to meet those needs.

We saw that staff on the wards met twice daily, at shift change over time. Midwifery and medical handovers were held separately as their shifts had different working pattern. We were able to attend both a midwifery and medical handover and saw effective communication in discussing patient needs and plans with the intention of maintaining continuity of care. Information was also captured in handover sheets to ensure all staff were kept up-to-date with relevant information.

The unit had a patient safety at a glance board which was a good tool to communicate with staff across the unit. These were kept out of view of patients and visitors to protect patient confidentiality.

We reviewed a birth place decision leaflet which provided information for patients and their partners about planning where to give birth within the health board area. The leaflet provided details of the services available at the unit. We found the wording within the leaflet could be made clearer in explaining the term ‘neonatal stabilisation unit’. We considered the current wording could be misleading and patients may believe that Special Care Baby Unit facilities are available at the unit. A clearer, non-medical explanation would ensure patients had a full understanding of the services available and enable them to make a better informed decision about their birth place choice. We advised the health board should consider the wording of the birth place decision leaflet.

We were told that if a patient had special requirements, such as a hearing loop or braille, the community midwife would inform the unit prior to the patient being admitted and suitable arrangements would be made.

Timely care

The patients we spoke to told us that staff were very helpful and would attend to their needs in a timely manner. Staff also told us that they would do their best to ensure patients were regularly checked for personal, nutritional and comfort

needs. This was also seen within the patient's records we reviewed. We also saw that call bells were seen to be easily accessible and answered in a timely manner.

We saw that patient observations were recorded on a recognised national chart to identify patients who may become unwell or develop sepsis. An appropriate sepsis guideline was in place and we were told that all midwives and obstetricians receive annual sepsis training.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit. We saw the corridors were well lit and clear of trip hazards and hand rails were positioned along each side of the walls.

The use of a language line was available for those patients whose first language was not English, meaning that they were able to access care appropriate to their needs.

We saw evidence within patient records that their personal beliefs and religious choice were captured during antenatal appointments. This helped to ensure they were upheld throughout their pregnancy, labour and postnatal care. We also saw that care plans also promoted people's independence based on their assessed abilities.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes to ensure that all members of the team were informed of patient preferences.

We were told that visiting was available between 2.00pm and 4.00pm and 6.00pm and 8.00pm; however partners and siblings were welcomed all day. A meeting room was located just outside the entrance to the unit where patients could meet with family and friends away from the unit if needed.

Patients we spoke to told us that their partners had been welcomed to stay on the unit for as long as they had wanted to stay. One partner said that, as his wife was in her own room, he had stayed with her all night and slept in the armchair next to the bed. We were also told that birthing partners could stay with the patient during labour. We were told by staff that there was a dedicated room with a double bed so that partners could stay if necessary.

Most of the patients who completed questionnaires said that the hospital visiting hours meant a partner or someone else close to them had been able to stay with them for as long as they wanted to. Around half of respondents confirmed their postnatal stay had been more than 24 hours, the remainder said it was 12 to 24 hours.

The hospital provided a chaplaincy service and there was a hospital chapel. We were also told about arrangements to enable patients from different faiths to access a prayer room to meet their spiritual needs.

Listening and learning from feedback

We saw that patient feedback was sought from patients. An information card was contained within the discharge pack provided to each patient which invited comments about the care and treatment received. Information was also displayed on the reception desk and within the meeting room outside the unit, advising patients and their partners or families how they can provide feedback about their care. Staff told us that if an individual member of staff had been named in the feedback, they would be informed by a manager.

All staff who completed questionnaires said that patient experience feedback (e.g. patient surveys) was collected, however only around half said they received regular updates on the patient experience feedback. We advised that the health board should consider how all staff can be made aware of patient feedback. All respondents said patient feedback is used to make informed decisions within the unit.

A process was in place for addressing informal complaints, with the intention of resolving them promptly. We were told that a ward manager would contact the patient offering to discuss their issues, as well as promoting the formal complaint route should patients wish to follow this. Leaflets were visible within the unit providing information on the complaints process.

We saw information leaflets relating to the NHS (Wales) Putting Things Right[5] complaints procedure for patients which provided clear information about how to

[5] Putting Things Right relates to the integrated processes for raising, investigation of and learning from concerns within the NHS across Wales.

raise any concerns they may have. This included details of the Community Health Council (CHC)[6] who could provide advocacy and support to raise a concern about their care. Information on raising concerns and advocacy support was also available on the health board's website.

Information from the Patient Advice and Liaison Service (PALS) team was available on the nurses' station on the unit. Their role is to ensure there was an emphasis on obtaining views on the care and services provided.

[6] http://www.wales.nhs.uk/siteplus/899/home

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 identified an immediate concern during the course of our inspection. As a result, we were not assured that patient care could always be provided in a safe and effective way. This is because we identified an issue regarding the checking of resuscitation equipment for new born babies.

Sufficient measures are in place to ensure that babies were safe and secure within the unit. However, we recommended that abduction drills are regularly undertaken to ensure that safety is maintained in an emergency.

We recommended the service should consider a contingency plan until all newly appointed dedicated theatre staff are fully proficient in their roles.

The service adhered to appropriate arrangements for safeguarding procedures and a safeguarding maternity database had been introduced which allowed staff to access and update records.

We found there was a robust cleaning system in place for the birth pools.

Safe care

Managing risk and promoting health and safety

Overall, we found that the unit was visibly well maintained, clean, appropriately lit and well ventilated. The environment provided a very calming atmosphere. We found that safety was observed throughout the unit. However, we found the birthing room in the midwifery led unit was cluttered. Staff told us this was in the process of being addressed as the birthing room was being relocated and more space would be available in the new environment.

We considered the unit environment and found sufficient measures in place to ensure that babies were safe and secure within the unit. An appropriate guideline was in place across the health board for the promotion of safety and prevention of abduction of babies, however we were not assured that a multi-disciplinary abduction drill had been carried out within the previous 12 months, in line with the guideline. Abduction drills should be regularly undertaken to ensure that safety is maintained in an emergency.

We considered the safety of women using the birthing pool and were not assured that pool evacuation training had been carried out by all required staff. We spoke to staff and an inconsistent message was given, with one staff member informing us that staff had not received training recently, and another saying that training is provided to staff when they start at the unit. This meant there was a risk in the event of a patient collapsing, becoming unwell or in the event of an emergency that staff had not received the relevant training to ensure the safety of patients when using the birthing pool.

We looked at the arrangements within the unit for accessing emergency help and assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells. We found that the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate equipment, including a defibrillator.

Improvement needed

The health board must ensure that:

- Regular baby abduction drills are carried out in line with guidelines
- All required staff are trained in pool evacuation.

Preventing pressure and tissue damage

We considered whether pressure risk assessments were completed for patients when appropriate. We were told by staff that, whilst this is not current practice, a skin care bundle to include pressure ulcer care is being introduced within the new patient record documents. Further details of this is referred to within the ‘record keeping’ section of this report.

Infection prevention and control

We found that the clinical areas of the unit were clean and tidy. Personal protective equipment (PPE) was available in all areas and was being used by all

healthcare professionals. All of the patients who completed a questionnaire agreed the unit was both clean and tidy.

The inspection team observed all staff adhering to the standards of being Bare Below the Elbow[7] and saw good hygiene techniques. Hand washing and drying facilities were avilable, together with posters displaying the correct hand washing procedure to follow. Hand hygiene gels were available throughout the unit. We also saw evidence of regular hand hygiene audits taking place.

We saw that standard infection control precautions were being followed. We were told that an infection control audit had been carried out by the health board the week prior to the inspection, however the results and findings were yet to be received by the unit. We saw high compliance with infection prevention and control training.

En-suite rooms were available for patients use should there be a requirement for barrier nursing[8], to help prevent infections being transferred to other patients.

We reviewed the health board's cleaning policy for the birthing pools. We were assured the policy was robust which would ensure that the pools were appropriately cleaned and safe to use.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met throughout the day and night.

Staff told us patients had the choice of hot or cold food every day, and were encouraged to order both to ensure they had sufficient food. Facilities were also available for patients and their partners/carers to access or make food and drinks outside of core hours, which allowed for nutritional needs to be met throughout the day and night. Hot and cold drinks were also readily available. We saw that

[7] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

[8] A way of preventing the spread of infection from one person to another in hospital

every patient had a jug of water within easy reach which topped up when required. Patients told us they were happy with the quality of the food provided.

We were told that options were available for patients with special dietary requirements such as allergies, intolerances or religious or cultural requirements.

In the patient care records we reviewed, we found that patient nutritional and fluid requirements were well documented. We also saw evidence within the unit of patients Intravenous (IV)[9] fluids being monitored and recorded on the All Wales fluid balance charts.

Medicines management

We considered the arrangements for the storage and administration of medicines within the unit. We found there were suitable arrangements for the safe and secure storage and administration of controlled drugs. However, we found a blood bottle and thermotrace code lead (a lead used on equipment within the stabilisation unit) on the unit which were out of date. This was escalated to senior staff and the items removed straight away. We were also assured that staff had been reminded of the importance of the consistant checking of equipment.

There were daily checks of the refridgerator temperature at which medication was stored, however the temperature parameters within which they should be stored were not visible on the refridgerators. This was discussed with staff and notices displaying the temperature parameters were immediately displayed on the refridgerators. This would assist staff in easily identifying whether medication was being stores at an appropriate temperature.

We looked at a sample of medication records and saw they had been completed correctly. Pharmacy support was available to the unit and out-of-hours access to medication was available from the emergency department.

[9] A way of delivering fluid directly into a vein

Improvement needed

The health board must ensure that all equipment is regularly checked within appropriate timescales to ensure it is in date and safe for use.

Safeguarding children and adults at risk

The health board has policies and procedures in place to identify, promote and protect the welfare of children and adults who were vulnerable or at risk. The service has a lead safeguarding midwife for the health board who would provide support and training to staff.

Safeguarding training is mandatory for all midwives within the unit and we saw that the compliance rate was high. We saw a safeguarding maternity database had been recently introduced which will allow all staff to obtain easy access to records and provided them with the ability to update records for vulnerable adults and children where necessary.

We reviewed of a sample of antenatal medical notes and saw that safeguarding issues had been highlighted and escalated appropriately. We were assured that appropriate procedures were in place to alert staff to safeguarding concerns with regards to patients being admitted onto the unit, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

We considered the arrangements for the checking of emergency equipment throughout the unit. We found that checks of equipment used in a patient emergency were insufficient as they were not recorded as being carried out on a daily basis. We found this in relation to neo-natal resuscitaires and emergency resuscitation equipment located outside the stabilisation unit on the labour ward and outside the operating theatre area.

Our concern regarding this issue were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial action was taken. Details of the immediate improvements we identified are provided in Appendix B.

Effective care

Safe and clinically effective care

During the course of the inspection, we observed midwives and medical staff practicing evidence based care in line with local and national guidelines which we considered to be best practice.

The inspection team considered the availability of a resident 24 hour theatre team in the event of out of hours emergencies, including emergency caesarean sections. At the time of the inspection, theatre staff were not on-site between 9.00pm and 9.00am, but were on-call and able to access the hospital within 30 minutes in the event of an emergency. Staff told us that, as of November 2019, an out of hours 24 hour resident theatre team would be in place. We were told that additional staff had been appointed into the vacant out of hour roles. However, concerns were raised by staff as there would be a transitional period during which new staff would undergo training and require time to gain experience to become fully proficient in their roles. We considered this to be a potential risk to the provision of safe and effective care to patients and recommended that the health board consider a contingency plan during the transitional period.

We looked at the referral process for maternity patients who attended the emergency department (ED) at the hospital. We considered that the wording of the referral process could be misinterpreted by ED staff, which could mean that not all maternity patients who present to the ED are reiviewed by an obstetrician or midwife. We recommend that the wording of the pathway is reviewed to ensure that safe and effective care will be provided to maternity patients by the appropriate medical staff.

We saw there was a maternity escalation process and regular recording and monitoring of daily acuity in place to ensure that staffing levels were monitored. This would ensure that services could be maintained safely and effectively. Staff that we spoke to were aware of the escalation policy and what action to take.

The inspection team considered ultrasound scan[10] reporting. We identified that the automatic reporting default was to a false report of breech position[11]. We considered this to be a risk to the delivery of safe and effective care as the reporting was innaccurate, unless the default position of breech was manually changed. We immeditaley raised this matter with senior staff and were assured that this was immediately addressed. All relevant staff had been reminded of the importance of considering the automatic default and the potential of inaccurate reporting prior to reporting on the scan. It was positive to find that staff reacted promptly to address this issue.

We also considered the first trimester screening scan reports and found inconsistencies in the quality of the reports. This included estimated fetal weight (EFW) not being recorded and heart views being unobtainable. We were told by staff that obstetricians are reliant upon sonographers[12] reporting on obstetrics imaging to inform their decision making. We recommend a robust audit process of the first trimester scan reports is introduced to ensure accurate and consistent reporting with oversight of this undertaken within the health board.

All patients who completed a questionnaire told us that a midwife stayed with them during labour and the pain relief received during labour was adequate. We also noted that pain relief had been provided in a timely manner in the patient records we reviewed.

All staff members who completed a questionnaire said that if they were concerned about unsafe clinical practice they would know how to report it. Most staff said they would feel secure raising concerns about unsafe clinical practice and felt confident their organisation would address their concerns.

---

[10] An ultrasound scan is a procedure that uses high-frequency waves that are transmitted through the abdomen and can be used during pregnancy to show images of the baby in the womb.

[11] When the baby in the womb has their feet or bottom facing downwards late in pregnancy. Babies in the breech position are often born by a caesarean section as it is considered to be safer.

[12] A sonographer is a healthcare professional who uses special imaging equipment to conduct ultrasound scans.

Quality improvement, research and innovation

The unit currently has access to a mental health nurse to provide support for perinatal mental health. We were told that measures were also underway to recruite a perinatal mental health midwife for the benefit of the maternity units across the health board. This would provide mental health support to patients during the pregnancy, labour, birth and the postnatal period. We reviewed a leaflet which is produced by the perinatal mental health service and found it to be a useful source of information for women which included details of services available and signposting to other support services.

We saw good initiatives developed by the consultant midwife with the introduction of birth choice clinics. These provided women with an opportunity to explore their birth choices and provide them with information in a balanced, understandable and individualised way.

Information governance and communications technology

Patient information was securely managed and stored throughout the unit to uphold patient confidentiality and to prevent unauthorised access. Patient records were contained within a room within the unit which could only be accessed with a swipe card.

The internal intranet was informative with a range of accessible midwifery and medical clinical policies and guidelines for staff. However, some of this information was found to be out-of-date and in need of review. We spoke to senior managers who said that all policies and guidelines were currently under review and the process would be completed by the end of December 2019.

Record keeping

We considered a sample of patient records within the unit. Overall, we found patient records had been well maintained; however, they were disorganised and difficult to navigate.

We found the following areas where the standard of record keeping and documentation needed improvement and consistency:

- Evidence of carbon monoxide testing for those patients who indicated they smoke, in line with NICE guidelines[13]
- Surgery notes to include the recording of the time a caesarean section was performed
- Evidence of in depth discussion regarding risks and benefits in choosing place of birth
- Consistent completion of signatures and General Medical Council registration numbers
- Consistent completion of GAP/GROW charts[14].

We saw that the health board had recently introduced new patient maternity booklets, which inlcuded separate booklets for antental inpatient record, skin care bundle, induction of labour and postnatal care. This should improve the navigation of patient records in future.

Improvement needed

The health board must ensure that patient records are clearly organised and fully reflective of the care and standard provided to patients in line with the standards of professional record keeping.

[13] https://www.nice.org.uk/guidance/ph26/chapter/1-Recommendations#effective-interventions

[14] GAP/GROWTH – Assessment protocol (GAP) has been shown to significantly increase the detection of fetal growth restriction which is a significant cause of stillbirth, neonatal death and perinatal morbidity

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.

The midwifery team were cohesive and had a good relationship with senior managers.

We found the service had in place a number of regular meetings to improve services and strengthen governance arrangements.

A monthly maternity risk management newsletter is produced which is a good communication tool in conveying information to staff across the maternity units across the health board.

Midwives were due to attend additional neonatal intensive care training within another health board.

Improvements could be made in networking and collaboration between medical staff at Bronglais and Glangwili maternity units.

Governance, leadership and accountability

We saw that the health board had a dedicated lead midwife for clinical risk and governance in place. They had responsibility for reviewing, investigating and managing clinical incidents. We saw that a clear and robust process was in place for managing incidents across the health board. Information relating to clinical incidents, investigations and their findings were shared at a range of meetings. This included risk management meetings, labour ward forums and monthly quality safety and patient experience meetings.

A monthly maternity risk management newsletter was produced which included key findings from the investigations and reviews undertaken and communicated any themes and trends to staff. We saw this to be a good communication tool in conveying information to staff across the maternity units across the health board, as well as inviting suggestions for inclusion from staff. In addition, weekly management meetings and midwife band 7 meetings took place.

The unit was using a maternity dashboard which is an electronic tool to monitor the clinical performance and governance of their services. This meant there was a good level of oversight of clinical activities and patient outcomes. The dashboard provided information with regard to clinical activity on the unit, which included the number and category of births (vaginal, caesarean section, assisted), number of homebirths, and also clinical indicators such as intensive care admissions, blood transfusions, neonatal admissions and neonatal morbidity. The dashboard was rated red, amber and green depending upon the level of risk associated with the numbers and figures. It was updated monthly and discussed at the labour ward forum and the quality, safety and patient experience meetings. Information from the dashboard was also shared to staff via the monthly risk management newsletter.

We spoke to medical staff in the unit who felt that improvements could be made in networking and collaboration between medical staff at Bronglais and Glangwili maternity units. Staff also expressed that improvements could be made with the communication of risks and the investigation of incidents which could be shared between the two sites. This could lead to closer working relationships between medical staff at the two sites in providing safe and effective care to patients who receive antenatal care at Bronglais hospital, but deliver their baby at Glangwili hospital.

Around half of staff who completed questionnaires agreed they were informed about errors, near misses and incidents that happen in the unit. The majority of staff said they were given feedback about changes made in response to reported errors, near misses and incidents.

The majority of respondents agreed staff who are involved in an error, near miss or incident are treated fairly. Most agreed that their organisation encourages them to report errors, near misses or incidents and none disagreed.

Around half of respondents agreed that the organisation would blame or punish the people who are involved in such incidents.

Improvement needed

The health board must ensure that a review of the adequacy of communication channels between medical staff at Bronglais and Glangwili units is undertaken to improve communication and collaborative working.

Staff and resources

Workforce

We saw that the midwifery team within the unit were cohesive and had a good relationship with senior managers. Midwives were seen to be confident, competent and sure of their practice. We also saw evidence of excellent working relationships, respect and good lines of communication between consultants and midwives. This demonstrated good team working and supported the provision of safe and effective care.

We spoke to staff within the unit who told us they always felt supported by senior managers. Staff told us that they always received advice and support from the on-call manager whenever required. The majority of staff who completed a questionnaire agreed that their manager always or usually encouraged those who work for them to work as a team. A majority said there was always or usually effective communication between senior management and staff. However, one member of staff commented that they would like to see senior managers more frequently at the unit. A majority of respondents said senior managers involve staff in important decisions and that management always or usually act on staff feedback. Half of respondents said management always or usually ask for their opinion before making decisions which affect their work, and one said they never do.

We saw that midwifery and medical rotas were well managed within the unit. We saw there was an escalation process in place and staff we spoke to were aware of how to escalate issues when required. We also saw that medical sickness absence was low within the unit.

We saw that the service had recently appointed a consultant obstetrician gynaecologist and clinical lead for obstetrics. Whilst relatively new in post, staff we spoke to said that they had brought enthusiasm and positivity to the unit.

We saw that midwives were issued with individual training portfolio documents which documented the mandatory training required of midwives, as well as signposting additional learning that was available to them. The service holds three mandatory maternity related study days across the year. One of the days

is Practical Obstetric Multi-Professional Training (PROMPT)[15] training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations.

Other mandatory study days included fire safety training, adult safeguarding, maternal basic life support and newborn resuscitation amongst other topics. Additional study days were available for staff, which included cannulation, IV drug administration and cardiotocography[16] (CTG) masterclass.

We were shown compliance figures for mandatory training and were assured that regular training was taking place. Compliance was monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales. Most staff who completed questionnaires told us that they had undertaken training in the last 12 months which helped them to do their job more effectively. However, some staff said they would benefit from additional training, secifically breastfeeding training. Most respondents said the general training provided helps them to stay up-to-date with professional requirements and the majority said it helps them deliver a better experience for patients. In addition, we saw that staff were required to complete mandatory E-learning which included infection prevention and control and safeguarding.

We considered whether additional training was provided to midwives in caring for babies within the stabilisation unit prior to transfer to a special care baby unit or neonatal intensive care unit. We discussed this with a senior manager and were assured that staff had already received the necessary training. Arrangements were in place for midwives to attend additional neonatal intensive care training within another health board. We reviewed the content of the training which we considered to be robust and demonstrated committment to maintaing skills.

[15] PROMPT – Practical Obstetric and Multi-Professional Training. The course teaches attendees how to deal with obstetric emergencies.

[16] A technical means of recording the fetal heartbeat and the uterine contractions during pregnancy

As described earlier in the report, we identified issues regarding the training of pool evacuation. A recommendation in relation to this has been made in the ‘safe and clinically effective care’ section of the report.

All staff who completed a questionnaire told us they had an appraisal, annual review or development review of their work in the last 12 months. Most who had reviews said their learning or development needs were identified, and most told us that their manager always supported them to achieve these needs.

3. 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, measurable, 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.

4. 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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Hospital: Bronglais Hospital

Ward/department: Maternity services

Date of inspection: 21 – 23 October 2019

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
The health board must provide HIW with details of the action it will take to: Ensure that checks of the neo-natal resuscitaires and emergency resuscitation equipment are carried out on a daily basis and in line with their policy.	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment and Diagnostic Systems	Operational Lead Midwife to receive weekly assurance audits from Band 7 ward managers to monitor compliance of equipment checking. Operational Lead from Glangwili Hospital/ Consultant Midwife to conduct weekly assurance audit to provide external scrutiny. Staff to be reminded regarding importance and requirements for consistent checking of equipment via	Head of Midwifery Head of Midwifery Head of Midwifery	Complete Complete Complete

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		safety brief, ward ‘Hot File’ and Risk Newsletter.		

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): Julie Jenkins

Job role: Head of Midwifery

Date: 28/10/19

Appendix C – Improvement plan

Hospital: Bronglais Hospital

Ward/department: Maternity Services

Date of inspection: 21 – 23 October 2019

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				
The health board must ensure that smoking cessation information is readily available throughout the unit.	1.1 Health promotion, protection and improvement	Information posters regarding smoking cessation to be displayed on all ward areas.	Head of Midwifery & Women Services	31 January 2020
The health board should consider the location of the bereavement room on the ward to ensure the privacy and dignity of the patient and their partner/carer are maintained.	4.1 Dignified Care	Relocate the bereavement room to the Midwifery Led Room situated at the end of Gwenllian Ward	Head of Midwifery & Women Services	31 January 2020
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • Regular baby abduction drills are carried out in line with guidelines • All required staff are trained in pool evacuation.	2.1 Managing risk and promoting health and safety	Undertake a bi-annual baby abduction drills and monitor results and discuss at Directorate Quality and Safety.	Head of Midwifery & Women Services	31 January 2020
		Remind all staff regarding vigilance when leaving staff, visitors along with patients in and out of clinical areas via Clinical Risk Newsletter, Safety Brief, handover sheet, and Hot File.	Head of Midwifery & Women Services	Completed
		Discuss with manual handling trainer the formal recognition of the in-house training by the Band 7 Midwifery Led Coordinator.	Head of Midwifery & Women Services	Completed
		Share the HDUHB Standing Operating process which is compliant with Midwifery Led Care and adheres to the All Wales Midwifery Led Care Guidelines on Water births via Clinical Risk Newsletter.	Head of Midwifery & Women Services	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		HDUHB Standing Operating process for Water births to be available via the HDUHB intranet under policies and guidelines. HDUHB Standing Operating process for evacuation form a birthing pool to be in all delivery rooms where women access water birth. Evacuation drills to be conducted monthly with all staff working within a Midwifery Led Unit.	Head of Midwifery & Women Services Head of Midwifery & Women Services Head of Midwifery & Women Services	Completed Completed Completed
The health board must ensure that all equipment is regularly checked within appropriate timescales to ensure it is in date and safe for use.	2.9 Medical devices, equipment and diagnostic systems	Operational Lead Midwife to receive weekly assurance audits from Band 7 ward managers to monitor compliance of equipment checking. External Operational Lead/ Consultant Midwife to conduct weekly assurance audit to provide external scrutiny. Staff to be reminded regarding importance and requirements for consistent checking of equipment via	Head of Midwifery & Women Services Head of Midwifery & Women Services Head of Midwifery & Women Services	Completed Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		safety brief, ward 'Hot File' and Risk Newsletter.		
The health board must ensure that patient records are clearly organised and fully reflective of the care and standard provided to patients in line with the standards of professional record keeping.	3.5 Record keeping	Staff to be reminded of the importance of good record keeping via Clinical Risk Newsletter. Audit on record keeping standards conducted monthly as integral part of the maternity assurance process. Audits findings disseminated to staff either individually or in group discussions via Clinical Supervisor for Midwives.	Head of Midwifery & Women Services Head of Midwifery & Women Services Head of Midwifery & Women Services	Completed Completed Completed
Quality of management and leadership				
The health board must ensure that a review of the adequacy of communication channels between medical staff at Bronglais and Glangwili units is undertaken to improve communication and collaborative working.	Governance, Leadership and Accountability 7.1 Workforce	Monthly consultant meetings are held to discuss clinical cases with the MDT team across both sites. Monthly Labour Ward forum facilitated with engagement from both sites. Attendance logged to ensure open	Lead Obstetrician Head of Midwifery & Women Services	Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		transparent dialogue of lessons learnt across the Health Board.		
		Obstetric Consultants participating in 'Hot week' rota (Consultant Obstetrician working 9-5 Labour ward cover Monday to Friday on a rolling roster) in Glangwili General Hospital from January 2020 to maintain and enhance skills, competencies and partnership working.	Lead Obstetrician	Completed
		Middle Grade doctors given opportunity to rotate into Glangwili General Hospital Early Pregnancy Assessment Unit to maintain and develop competencies.	Lead Obstetrician	31 January 2020
		Clinical Risk Midwife facilitates table top learning events of any clinical incidents with the MDT team from both sites.	Head of Midwifery & Women Services	Completed

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): Julie Jenkins

Job role: Head of Midwifery

Date: 20 December 2019