Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

The Royal Glamorgan Hospital - Tirion Birth Centre / Cwm Taf Morgannwg University Health Board

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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 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 The Royal Glamorgan Hospital within Cwm Taf Morgannwg University Health Board on the 10, 11 and 12 September 2019. This inspection is part of HIW's national review of maternity services[1]. The following was visited during this inspection:

- Tirion Birth Centre (referred to throughout the report as the birth centre).

Our team, for the inspection comprised of three HIW inspectors (one lead), two peer reviewers 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

2. Summary of our inspection

Overall, we found that care was provided in a safe and effective manner. Staff within the Tirion Birth Centre demonstrated a clear passion and drive to provide high standards of care to patients, in a homely, relaxed environment.

This is what we found the service did well:

- Patients told us they were treated with dignity and kindness by staff
- The birth centre was very clean and tidy and furnished to a high standard
- Staff were committed to supporting women with their individual birth choices
- The service was able to offer a range of classes to women during the antenatal period
- There was a clear process for carrying out relevant and regular checks on the birth centre to uphold standards
- Weekly reflection sessions for staff to share learning and support practise development
- Staff reported they felt supported by management and felt confident to raise any issues of concern.

This is what we recommend the service could improve:

- Some minor improvements to record keeping to ensure consistency across all staff
- Ensure that patient records are kept secure at all times
- Consideration of whether there are sufficient numbers of health care support workers to provide cover during times of sickness and/or absence.

3. What we found

Background of the service

The Royal Glamorgan Hospital is located in Llantrisant and forms part of services provided by Cwm Taf Morgannwg University Health Board. The health board was formed on the 1 April 2019 and covers the areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

The health board has a catchment area for healthcare services containing a population of approximately 450,000. Acute, intermediate, primary, community and mental health services are all provided. Services are delivered in a variety of settings, including three district general hospitals; Royal Glamorgan, Prince Charles and Princess of Wales Hospitals.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

Women who birth within the health board have the choice of a number of birth settings. These include homebirths, a free-standing midwifery-led unit, midwife-led care at alongside midwifery units and obstetric units. Royal Glamorgan Hospital provides maternity services in a free-standing midwifery-led birth centre, known as the Tirion Birth Centre.

Tiron Birth Centre opened in March 2019, following a redesign of maternity services across Royal Glamorgan and Prince Charles Hospitals. This meant that maternity services at Royal Glamorgan Hospital are provided in a free-standing midwifery-led birth centre, supported by midwives.

In April 2019, the health boards' maternity services (based at Royal Glamorgan and Prince Charles Hospitals) were placed into special measures[2] by the Minister

[2] https://gov.wales/cwm-taf-morgannwg-maternity-services-put-special-measures-report-identifies-serious-failings

for Health and Social Services. This followed an independent review[3] of maternity services conducted by the Royal Colleges of Midwifery and Obstetrics and Gynaecology.

[3] https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board

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 we spoke with were highly complementary about the care and supported provided by staff at the birth centre.

We observed polite, friendly and supportive interactions between staff and patients that were delivered in a way that upheld patient dignity.

A range of antenatal classes were provided by birth centre staff, providing patients with support, choice and information about their preferred birth plans.

The birth centre was furnished to a high standard, allowing patient care to be delivered in a homely environment.

During the inspection, we spoke with patients at the birth centre. Due to the low number of patients at the time of inspection, we also telephoned patients who had recently delivered babies at the birth centre to obtain their views on the services provided. Patient comments included the following:

> *"I couldn't have asked for a better experience".*
>
> *"It was such a lovely birth".*
>
> *"The calm atmosphere at the unit contributed to my calm and amazing birth. Knowing that the midwives were trained in hypnobirthing meant I felt confident I'd get the birth I wanted".*

Staying healthy

We saw that a variety of information was available for patients to read throughout the birth centre. Information in relation to breastfeeding and skin to skin advice was displayed, to inform patients about the benefits of both breastfeeding and skin to skin contact, to help them make an informed decision about their care.

We were told that smoking cessation advice is provided during antenatal appointments and classes, with a support group available for those women wishing to stop smoking during pregnancy.

We were told that the birth centre was UNICEF[4] baby friend accredited, however we did not see any information displayed regarding this. The health board should consider whether displaying this information for patients would be beneficial. There was an infant feeding coordinator midwife appointed across the health board, however we were told that due to personnel changes the hours of support had recently been reduced. Some concerns were expressed with regards to this. We spoke with senior managers who told us they were looking at using current resources in different ways, to ensure that appropriate levels of support were provided to staff and patients.

Patients were able to readmit themselves onto the birth centre to receive breastfeeding support from staff. During the inspection, we saw evidence of this happening and patients we spoke with said the support they received had been excellent, allowing them to continue breastfeeding.

Dignified care

We looked at a sample of patient records and did not find any areas of concern with regards to dignified care being provided at the birth centre.

Patients we spoke with were highly complementary about the support provided by staff during their pregnancy, in labour and during postnatal care. Staff within the birth centre ran classes, such as hypnobirthing[5], latent phase[6], water birth, breastfeeding and postnatal[7] classes.

[4] https://www.unicef.org.uk/babyfriendly/

[5] Hypnobirthing is a method of pain management that can be used during labour and birth. It involves using a mixture of visualisation, relaxation and deep breathing techniques.

[6] The early stage of labour

[7] What to expect once the baby has been born

The birth centre had recently been refurbished and decorated to a high standard, and we found that this created a warm and welcoming homely environment. There were two birthing pools, which included changeable mood lighting. En-suite rooms were available which included double beds, allowing patients partners to stay with them overnight. There were soft furnishing that all helped to uphold a homely environment. Bathrobes and slippers were also available for patients to use.

There was a small kitchen for patients and their partners, allowing them the choice of making snacks and hot drinks when they wanted to.

We were told that the birth centre cares for patients who are considered low risk, and any patients would be transferred to an obstetric unit, should there be any indication of risk to either mother or baby.

Staff within the unit advised that they would be able to appropriately care for any recently bereaved parents. Whilst not having a dedicated bereavement room at the unit, staff told us that they would be able to support and care for any recently bereaved parents in one of the postnatal rooms. These had double beds, meaning that partners would also be able to stay. The health board had an appointed bereavement midwife who would be able to offer the appropriate support when needed.

Patient information

We found that directions to the birth centre were clearly displayed throughout the hospital, meaning that patients were able to find their way easily.

Staff we spoke with were aware of the translation services within the health board and how they were able to access these.

We were told that the birth centre has plans to hold two open days, allowing patients to be able to have discussions with staff about the centre and allow them to view the facilities. This aimed to promote the service and facilities available to patients and to provide information to support patients in making an informed decision. We encouraged the health board to ensure that these open days went ahead as planned, in order to provide potential patients with details of all birthing options available to them.

Communicating effectively

Patients we spoke with were very positive about their interactions with staff during their time at the birth centre. Patients told us that staff listened to them and acted upon their needs and wishes.

We saw that staff on the birthing unit met twice daily, at shift change over time. This was in order to communicate and discuss patient needs and plans with the intention of maintaining continuity of care. Information was also captured on a patient information board, kept in the staff office, providing up-to-date patient information. Details of the on-call community midwives were also included and checked on a daily basis to ensure that should they be required, staff had access to the most up-to-date information.

Timely care

Staff told us that they would ensure patients were regularly checked for personal, nutritional and comfort needs. We saw evidence of this within patient care records we looked at. Patients also told us that staff were attentive to their needs.

Staff we spoke with told us that there were appropriate processes in place to ensure that patient transfers to an obstetric unit would happen in a timely manner. We were told that staff had recently met with the Welsh Ambulance Service Trust (WAST) to ensure that patient transfer times were appropriate. We saw that staff training had been provided to support the smooth transfer of patients.

Patients were offered the choice to have their 36 week antenatal appointment at the birth centre. This would normally be carried out by community midwives, however, we were told that the community midwifery team had until recently a number of vacancies, which meant that these appointments could be delayed. We were told that these vacancies had recently been appointed into. Birth centre staff were able to offer some appointments to patients, meaning that they were able to be seen in a timely manner.

The staff we spoke with on the birthing unit told us that they were able to achieve high standards of care during their working day.

Individual care

Planning care to promote independence

The birth centre was on the first floor of the hospital and was easily accessible via lifts or stairs. There was designated parking for dropping off patients allowing them to enter the birth centre more easily.

The facilities throughout the birth centre were easy to access, allowing patients to move around in an uncluttered environment.

Patients told us that the staff listened to their wishes and respected their birth plans, with one patient commenting:

"Midwife was aware I had attended hypnobirthing and wanted minimum intervention".

Double beds were available in the birth centre, meaning that partners were able to stay and provide support to patients and babies during labour and the postnatal period.

The consultant midwife for the birth centre held regular birth choice clinics. This included a tour of the birth centre and discussions with women and their partners about the birthing options available to them. This provided women and their partners with information that support them in making informed decisions about their care.

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. We saw evidence of this within a sample of patient records we looked at.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit freely.

All of the birthing rooms were very well equipped, to support individual choice and to meet the patients' birth choices. Two of the birthing rooms also had birthing pools which allowed patients to use the pool during labour.

Listening and learning from feedback

We saw information leaflets and posters in the birth centre relating to the NHS Wales Putting Things Right[8] complaints procedure for patients to follow should they have concerns about their care. Staff and managers told us they would aim to deal with any complaints at source, with a view to resolving them quickly. Whilst there had not been any formal complaints received since the birth centre had opened, staff and managers described the process they would follow should they receive one.

[8] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

Information about the Community Health Council[9] was displayed, providing details about the support available from an independent organisation should a patient wish to raise a concern.

We saw many thank you cards displayed in the birth centre from patients, expressing their gratitude about the care and support received from staff. Patients were also able to leave feedback via a guest book, meaning that other patients were able to read about others experiences.

Weekly reflection sessions for staff were held at the birth centre (explored later within this report) and concerns, incidents or issues were discussed with a view to sharing learning amongst the team. Patient feedback was also discussed during these sessions.

The health board's maternity services directorate had recently implemented a monthly governance meeting. We saw that during this meeting there was a standing agenda item where feedback from women was discussed. This was with the intention of sharing and learning from patient feedback across the maternity directorate.

[9] http://www.wales.nhs.uk/sitesplus/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 found that care was provided to patients in a safe and effective way. Patient's birth choices were listened to and actively encouraged by staff.

The birth centre was clean and tidy, upholding the standards of infection control.

We saw that there were regular checks in place to ensure the environment and equipment remained safe to be used, with regular oversight of management.

We observed a good standard of record keeping, with some minor improvements necessary to ensure a high standard is maintained by all staff.

Hand sanitiser gels should be considered at the entrance to the birth centre.

Staff were reminded to ensure that patient records were kept secure and out of public view at all times.

Safe care

Managing risk and promoting health and safety

We found the birth centre to be uncluttered, clean, tidy and free from hazards. The operational lead for the birth centre carried out a daily walk-around, and would identify any issues that needed to be escalated to the appropriate department within the health board to rectify.

Staff were also required to carry out a number of checks of the birth centre, to help ensure that it remained safe for use. These included checks of the emergency drugs and equipment, the birth pool to make sure it had been cleaned, medication storage temperatures, fire safety checks and baby electronic baby band monitoring. We saw records demonstrating that these had been carried out consistently. The records also demonstrated that the birth centre

operational lead had oversight of this activity to ensure it had been completed. We were also told that this information is shared with senior managers on a regular basis.

The birth centre used an electronic tagging system to help prevent unauthorised removal of babies from the ward. We saw that these were in use during the course of the inspection. Part of the daily checks carried out by staff included checking the electronic tags were working, and we were assured appropriate action was taken to maintain security if an issue with the tags was identified.

We saw records showing that regular skills and drills training takes place in the birth centre, allowing staff to practice their emergency procedures to ensure they are prepared for such an eventuality. Examples provided included birth pool evacuations and the transfer process to an obstetric maternity unit. We were told that the birth centre staff would discuss their skills and drills at a weekly reflection meeting, to share learning and experiences. Community midwifery staff were also invited to attend these sessions, to help ensure that all staff using the birth centre had the same knowledge of their emergency procedures.

We were told that the birth centre had recently invited a member of WAST to share information regarding the equipment held in an ambulance for births. We were told that this was a positive and productive discussion, allowing the team to fully understand what equipment was required and how the birth centre team could fully support the ambulance staff whilst transferring a patient.

Falls prevention

The birth centre was tidy and free from any trip hazards. We were able to see that a risk assessment of the birthing pools had been carried out and suitable equipment available to provide immediate support to those needing to be evacuated out of the pools quickly. Staff told us that regular training sessions were held to ensure their skills were kept up-to-date regarding pool evacuations.

Infection prevention and control

We found the birth centre to be very clean and tidy.

We saw records to show that the birth pools were cleaned daily, regardless of whether or not they had been used. Regular testing of the water was also carried out.

Personal protective equipment (PPE) was available throughout the birth centre for staff to use. We observed staff upholding the standards of being bare below the elbow[10].

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. Whilst alcohol sanitiser gels were available inside the birth centre, none were available as staff, patients and visitors entered.

A health care assistant carried out a weekly hand hygiene audit, to help ensure that staff were up to date with their hand washing skills. We saw evidence that this was monitored regularly.

Improvement needed

The health board should consider whether additional alcohol sanitiser gels are required at the entrance to the birth centre to support effective infection control.

Nutrition and hydration

There was a small kitchen area within the birth centre, which allowed staff to make food for patients. Kettles were also available in the individual rooms allowing patients to make hot drinks for themselves when needed.

Patients received meals from the hospital kitchen and were able to choose what they wanted to eat. Domestic staff would then serve meals to the patients in their individual rooms. We were told that a variety of meals were available, including to cater for dietary requirements.

[10] 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.

During the inspection, some patients had admitted themselves back onto the birth centre for breastfeeding support. We saw that they were also provided with meals during their stay.

Medicines management

We found there were processes and procedures in place for the safe storage, administration and management of medicines in the birth centre.

We saw that the fridges used to store medicines were checked daily to ensure that the temperature was within the correct limits for safe storage. These were also locked to prevent unauthorised access. Controlled drugs were also stored securely in a locked cupboard. We viewed the records for the management of controlled drugs and found that the information was clearly recorded.

We saw that the operational lead carried out regular medicine management audits, to help ensure standards were maintained.

Safeguarding children and adults at risk

There was a safeguarding midwife appointed for the health board and staff were able to describe processes and procedures to follow in the event of a safeguarding concern. The majority of staff who completed a HIW questionnaire told us that they had received safeguarding training within the past 12 months.

Medical devices, equipment and diagnostic systems

We looked at the arrangements for checking the resuscitation equipment for patients and found there were appropriate processes in place to ensure that the equipment remained safe to use. We also saw that there was good oversight of these checks by the operational lead for the birth centre.

Regular checks were carried out of all the equipment available in the birth centre, this formed part of the routine daily, weekly and monthly checks carried out by the staff, overseen by the operational lead.

Effective care

Safe and clinically effective care

The birthing unit had the use of cardiotocography (CTG)[11] to predominately monitor antenatal patients who attend the day assessment unit within the birth centre. We were told that if there were any abnormalities detected in the fetal heart rate, patients would be referred and/or transferred to an obstetric unit for further assessment or action.

Patient and staff confirmed that patients in the birth centre were kept comfortable and well cared for. Pain relief was available and we were told that patients were provided with balanced information on using pain relief, to help them make an informed decision. For example, a patient wishing to have an epidural would need to be transferred to an obstetric unit and this would be explained by staff to ensure the patient was aware of the implications of their decision.

Staff we spoke with told us that they were happy with the quality of care they were able to give to their patients.

Quality improvement, research and innovation

We were told about a pilot project the health board is about to initiate, led by the public health midwife, which could potentially have an impact on the numbers of women able to access the services at the birth centre. It was explained that currently, women with a body mass index (BMI)[12] of between 35-40 have their antenatal care managed by a consultant. Therefore, those patients have their babies in an obstetric led unit. The pilot is to consider whether these patients, without any other risk factors, are able to receive their antenatal care from the community midwives, and be offered the option of having their baby in the birth centre. We were told there would be strict criteria for patients able to access this pilot and careful monitoring would form part of the process. Should the trial be successful, it would allow more choice for patients about their own birth plans.

We saw that the birth centre had recently been nominated for an award and the operational lead was due to present to the Royal College of Nursing shortly to determine the outcome. The presentation was going to tell the story of the maternity service change within the hospital (going from an obstetric maternity

[11] A machine used to record the fetal heartbeat, where continuous CTG monitoring is in place

[12] A measure that uses height and weight to work out if an individual's weight is healthy

unit to a stand-alone midwife-led birth centre) and the impact on staff, the local community and patients.

Information governance and communications technology

Staff told us they had access to the health board's intranet and were able to demonstrate where they would find policies and procedures relevant to their roles.

Patient records were in paper format and whilst a member of staff was generally on the desk in the birth centre, we did find on one occasion where patient records were left open on the desk. This meant that potentially other patients or visitors could have sight of confidential records.

Improvement needed

The health board must ensure that patient records are kept securely, out of view, at all times to maintain patient confidentiality.

Record keeping

We looked at a sample of patient records, and found that they were of a good standard. Records were easy to follow, clear, written contemporaneously and demonstrated the care provided. We found the use of all Wales documentation was consistently applied in the records we looked at.

Records evidenced that discussions with patients had covered their birth choices, including where and how they wished to have their baby. As demonstrated earlier in the report, one patient commented that they had attended hypnobirthing and wished to be left alone during labour, which the midwife listened too and acted upon.

We looked at some patient records where they had been transferred out to an obstetric unit either during labour or during the postnatal period. We found the documentation to be of a good standard, with clear and detailed recordings of the reasons why a patient had been transferred.

We found within the patients records we reviewed that the routine enquiry was inconsistently recorded. The routine enquiry is where a professional caring for a woman during the antenatal period asks questions in relation to her personal safety. This should be done, as a minimum, twice during the antenatal period and recorded as such.

We also found in some records where doctors handwriting was difficult to read, meaning it was often difficult to determine the care or decisions made by that professional.

Patients keep their own maternity records, and are responsible for taking them to their appointments. We found that the folder holding patient records was often in a poor state of repair. There was the potential for the records within the folder to become loose and misplaced due to the quality of the folder. Senior managers were aware of the issue and we were told that alternative suppliers were being considered.

Improvement needed

The health board must ensure that routine enquiries are clearly recorded and documented in line with national guidelines.

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 a highly positive and professional team of staff, who were working closely together to provide high standards of care.

There were sufficient managerial oversight of on the ward activities, to support the delivery of safe and effective care.

Staff were able to access training to allow them to develop their skills and knowledge appropriate to their roles.

Governance, leadership and accountability

In 2019, maternity services within the health board were reconfigured[13]. This meant that specialist medical care for women during labour are no longer available at Royal Glamorgan Hospital and are instead provided at Prince Charles Hospital. Maternity services at Royal Glamorgan Hospital became midwife led, with the opening of the birth centre in March 2019 including a small team of midwives and support staff.

As previously mentioned in the report, maternity services within the health board were placed into special measures in April 2019. This meant that Welsh Government instructed an independent maternity oversight panel[14] to monitor improvements within services. Regular weekly telephone discussions are held with Welsh Government in order to discuss the maternity dashboard, which

[13] https://cwmtafmorgannwg.wales/how-we-work/plans-and-reports/changes-to-childrens-inpatient-and-maternity-services-at-royal-glamorgan-hospital/

[14] https://gov.wales/independent-maternity-services-oversight-panel

includes areas such as staffing, clinical activity, risk incidents, clinical outcomes and training.

Whilst the birth centre was opened after maternity services were placed into special measures, we were able to see that activity specific to the birth centre was still considered and monitored in the weekly dashboard information provided.

Staff we spoke with were very positive about the birth centre, the support they received from management and their ability to provide care and support to their patients in an environment which supports the ethos of a stand-alone midwife-led birth centre. We were able to see that staff had been involved in decision making regarding setting up the birth centre. Staff said they felt supported by managers, felt they would be listened to and were able to raise issues or concerns freely.

Managers described the process for investigating concerns or incidents, and staff we spoke with told us they were able to use an electronic incident reporting system and that they were encouraged to do so. Weekly reflective sessions were held at the birth centre, where staff were encouraged to discuss any issues they had experienced, to ensure that lessons could be learned and shared across the centre. Staff told us they found to be a beneficial and helpful process. Feedback from any formal complaints, concerns or incident reviews would also be shared and discussed during these meetings.

There were clear processes in place to ensure that the day to day activity on the unit was safe. As previously mentioned, this included daily, weekly and monthly checks and audits carried out by staff. These were overseen by the operational lead, who was required to provide assurances to senior managers that this activity was taking place, and to report any adverse findings on a regular basis.

We were able to see that there were a number of forums, created for the wider health board maternity services, where specialist midwives and clinical leads were invited to attend to discuss relevant issues and share information. These included a number of clinical forums, such as antenatal and screening and labour ward, and also overall governance forums such as training and education and clinical incidents reviews. Staff reported these meetings to be a positive introduction.

The health board had recently implemented a monthly multidisciplinary governance meeting. We were able to attend part of one of these meetings during the inspection. We saw that it was an avenue for cases to be discussed from across the health boards maternity services, lessons learned and shared across the service. Patient views and feedback was also discussed during the meetings.

There was a lead governance and risk midwife appointed for maternity services across the health board. We were able to see that regular incident meetings were held in two of the health boards' maternity sites, Prince Charles and Princess of Wales Hospitals. All staff were able to attend the meetings, and discussions would be held regarding recent cases, to enable learning to be shared. A weekly newsletter was produced following the meetings and shared with all staff, including those based at the birth centre, which included key messages to support development and learning. We saw that the newsletter also highlighted good practice too.

Staff and resources

Workforce

Staff we spoke with were overwhelmingly positive about the birth centre and the changes they had experienced over the previous few months. We found a team of professionals who were passionate about their work and demonstrated a desire to provide safe and effective care to patients in an environment that they felt supported in by managers. We observed a positive team spirit within the birth centre and staff we spoke with told us they were happy in their roles.

We spoke with birth centre staff and managers and looked at rotas and found that there were appropriate levels of staff to enable them to provide safe and effective care. Staff told us that the numbers of patients delivering at the birth centre were increasing month on month, but that currently they had sufficient staff to allow them to provide the care they needed to. We were able to see that there was a rota and process in place for staff to call in community midwives to provide additional support should the numbers of patients increase during a shift.

Whilst the staffing compliment was appropriate to the needs of the birth centre, due to it being a small team sickness could have a potential negative impact as there were limited resources to provide additional support. We were told that the team worked very well together, and cover for shifts due to sickness was managed by the team. During the inspection, we saw that this worked well due to a member of staff being un-expectantly absent. We saw that staff were willing to change and alter shifts to cover the absence, as well as the operational lead and day assessment unit midwife providing clinical support when needed, to ensure care was able to be provided safely. We were told that they were able to use resources from community midwives if needed.

The birth centre had a number of health care support workers, who worked alongside the midwives during each shift. We were told and were able to see through rotas, that there had been occasions where a health care support worker

was not available and a midwife had backfilled this role. Whilst we were told that this was done to ensure that the birth centre was able to be sufficiently staffed, we questioned whether the utilisation of midwives to fill these roles was the best use of the resource.

We considered the training arrangements for staff on the birth centre and found there to be appropriate processes in place for ensuring that staff were able to attend training to maintain their skills. The operational lead booked staff onto relevant training and monitored their attendance. Attendance at training was also monitored by professional midwife training coordinators and senior management. There was a health board training and education forum, chaired by the deputy head of midwifery, where training compliance was discussed. We were able to see that staff had attended training specific to the birth centre, to allow them to develop their skills. We were also able to see that these were tested, through skills and drills training, on a regular basis and discussed during weekly reflection sessions by the team. We were told that community midwives were also invited to attend training, and were also invited to the weekly reflection sessions. Staff told us that they found the sessions beneficial, as it gave them an opportunity for reflective practice within a professional and supportive environment.

We were able to see records to show that staff had either attended, or had been booked onto, the required mandatory three study days to help ensure they were up-to-date with relevant skills and knowledge. This included PROMPT[15] training.

We were able to see records to show that most staff had received an appraisal of their work within the last year. We were told that there was a plan in place to ensure that those who had not received one, would have one by the end of October. Clinical supervision was provided by the supervisor of midwives and they were required to complete four hours a year, in line with national guidelines.

A new process had recently been introduced for band six midwives and was in the process of being rolled out across the health board. This meant that band six midwives are required to complete a passport on an annual basis to demonstrate the skills and knowledge required to undertake the role.

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

Improvement needed

The health board must consider whether there are sufficient numbers of health care support workers at the birth centre to provide the appropriate levels of care and support to patients and midwives.

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, 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.

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
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement plan

Hospital: The Royal Glamorgan

Ward/department: Tirion Birth Centre

Date of inspection: 10, 11, 12 September 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
No immediate assurance issues were identified on this inspection.				

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 – Immediate improvement plan

Hospital: The Royal Glamorgan

Ward/department: Tirion Birth Centre

Date of inspection: 10, 11, 12 September 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				
No areas of improvement identified				
Delivery of safe and effective care				
The health board should consider whether additional alcohol sanitiser gels are required at the entrance to the birth centre to support effective infection control.	2.4 Infection Prevention and Control (IPC) and Decontamination	Alcohol sanitiser gels are now in place at the entrance to the Birth Centre	Tirion Lead	Completed 30th September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that patient records are kept securely, out of view, at all times to maintain patient confidentiality.	3.4 Information Governance and Communications Technology	All case notes are now kept out of view and stored securely in the treatment room with the door closed. Spot Checks to ensure compliance are now undertaken on a weekly basis by the Senior Midwife	Senior Midwife	Completed 30th September 2019
The health board must ensure that routine enquiries are clearly recorded and documented in line with national guidelines.	3.5 Record keeping	We had identified improvements were required to increase compliance with routine enquiry. The results of our own audit have been shared with staff in team meetings. Regular ongoing audits are in place to monitor compliance.	Lead Midwife Safeguarding	Completed 30th September 2019
Quality of management and leadership				
The health board must consider whether there are sufficient numbers of health care support workers at the birth centre to provide the appropriate levels of care and support to patients and midwives.	7.1 Workforce	There are a total 6.28wte healthcare support workers employed for the Birth Centre to support the minimal staffing requirements of one health care support worker per shift 24/7. Recent deficits have been as a result of short term	Senior Midwife	Completed 30th October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		sickness and Maternity leave. Current sickness rate 0% Staffing levels are monitored weekly by the senior midwife. Any issues are escalated to our monitoring dashboard weekly. Staffing levels are reported monthly at the directorate business meeting		

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): Jane Phillips

Job role: Head of Midwifery

Date: 31.10.19