Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Glangwili Hospital / Maternity Services – Labour Ward, Dinefwr Ward and Midwifery Led Unit, Hywel Dda University Health Board

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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 Glangwili Hospital within Hywel Dda University Health Board on the 7, 8 and 9 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:

- Antenatal ward (before delivery), triage assessment area
- Labour ward (during delivery)
- Postnatal ward (following delivery)
- Midwifery Led Unit
- One operating theatre.

Our team for the inspection comprised of two HIW Inspectors (one lead), 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

2. Summary of our inspection

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

However, we identified a number of improvements were required to ensure that the service was providing safe and effective care at all times and to meet national guidance and the Health and Care Standards.

This is what we found the service did well:

- Patients and their families were positive about the care and treatment provided during their time in the unit
- We saw professional and kind interaction between staff and patients, and care provided in a dignified way
- All patients felt that staff had explained their birth options and any risks related to their pregnancy
- The midwifery led unit was a pleasant, welcoming and homely environment.

This is what we recommend the service could improve:

- Low morale and well-being amongst the staff teams
- Some areas of patient record keeping
- Secure storage of medication to prevent unauthorised access and to uphold patient safety
- Inconsistencies in staff compliance with statutory and mandatory training for all healthcare professionals
- Insufficient audit activity being carried out on the ward.

3. What we found

Background of the service

Glangwili Hospital is located in Carmarthen, 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 (183,936), Ceredigion (79,488) and Pembrokeshire (120,576). It provides Acute, Primary, Community, Mental Health and Learning Disabilities services via General and Community Hospitals, Health Centres, GP's, Dentists, Pharmacists and Optometrists and other sites. 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.

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 2,500 of these at Glangwili 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. Glangwili Hospital comprises of an obstetric led unit together with an alongside midwifery led unit. All midwife led intrapartum care settings have access to the Obstetric unit when complications arise in labour.

Glangwili hospital is currently undertaking a major refurbishment of its maternity unit which was commenced in September 2018. The new unit will include more birthing rooms, a high dependency theatre and a dedicated bereavement area. The work is due to be completed in 2020.

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.

Most patients told us that the care and support they received had been excellent. We observed staff speaking to patients and their families with kindness and respect.

All of the patients said they had good support to help them feed the babies by their chosen method and midwives had respected their decision.

The service had a dedicated bereavement room to support recently bereaved parents and their families.

Improvements are required around information throughout the unit being made available bilingually. In addition, Smoking cessation advice should be made available throughout the unit.

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the services provided. A total of 10 questionnaires were completed. We also spoke to four patients during the inspection.

Overall, patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent. Patients and their families who we spoke with also said they had a good experience. Patient comments included:

> *"My pregnancy was high risk due to other medical problems that many would not see on a day to day basis. The support I have had is fantastic."*

> *"All members of staff very friendly and supportive."*

Most patients who completed a questionnaire said they were offered a choice about where to have their baby and nearly all agreed the midwife asked how they were feeling and coping emotionally in the antenatal period. One patient commented:

"Was given options when asked she had very good knowledge of benefits and disadvantages of each one."

All of the respondents agreed the unit was tidy and most agreed the unit was clean.

Staying healthy

We saw that information was displayed for patients on notice boards and in leaflets. Information in relation to breastfeeding and skin to skin advice was displayed in the corridors, to provide support and information to patients about the benefits allowing for an informed decision to be made about their care. There was no information visible on the wards relating to smoking cessation which would promote the health of patients both during and after pregnancy.

We saw a plaque on the wall stating the wards were UNICEF[2] baby friendly, accredited in 2018 which confirmed compliance with this.

Improvement needed

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

Dignified care

During the course of our inspection we saw staff speaking to patients and their families with kindness and respect. Patients told us that staff were courteous and took the time to support them, even though they could see that staff were exceptionally busy at times.

A majority of patients who completed the questionnaire confirmed that they were offered the option to communicate with staff in the language of their choice.

[2] 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 Organization (WHO) and Unicef.

We saw curtains were drawn around patient beds whilst staff were providing personal care and support to uphold patient privacy and dignity. However, we observed shared four bed bay areas within the postnatal area with curtains separating the beds. This meant that other patients or visitors could hear confidential discussions taking place if patients were spoken to in the room when other patients and/or partners were present.

There were en-suite facilities within some of the birthing and postnatal rooms which maintained dignity during the patient's stay. Where en-suite facilities were not available, shared facilities were available nearby.

We saw there was a toilet and shower room available on the postnatal ward for partners. There was also a room available which contained a reclining chair for partners who wanted to stay on the unit overnight.

The service had a dedicated bereavement room on the antenatal ward, to support recently bereaved parents. We found the room to be a calm and welcoming environment. We were informed by staff that the unit had a bereavement lead, however we were unable to speak to them during the inspection.

Nearly all staff who completed a questionnaire said that the privacy and dignity of patients is always or usually maintained.

Only two of the patients who completed a questionnaire said they saw the same midwife in the maternity unit as they did at their antenatal appointments. The majority of patients were six to 12 weeks pregnant when they had their booking appointment. Most patients said they were offered a choice about where to have their baby and nearly all agreed the midwife asked how they were feeling and coping emotionally in the antenatal period.

Most patients who completed a questionnaire told us that a midwife stayed with them during labour. The patients also said the pain relief received during labour was adequate. The majority of patients felt that they and their partners received enough support from staff to help them cope to work with the pain of labour. Half of the patients who completed a questionnaire said, when giving birth, they required the use of forceps/ventouse[3] to assist the delivery.

[3] https://www.nhs.uk/conditions/pregnancy-and-baby/ventouse-forceps-delivery/

Most patients said that hospital visiting hours meant a partner or someone else close to them had not been able to stay with them for as long as they wanted to. Half of respondents confirmed their postnatal stay had been more than 24 hours.

A minority of patients agreed that midwives had talked to them about the emotional changes they may experience after giving birth, though few disagreed. All of the patients said they had enough support to help them feed the baby by their chosen method and midwives had respected their decision.

Improvement needed

The health board should:

- Consider how the privacy of patients can be maintained if staff have discussions in the open plan bay area
- Consider gaining patients' views regarding visiting access of birthing partners.

Patient information

Whilst we found the directions to the midwifery led unit were clear, we found that directions to the other maternity wards were not clearly displayed throughout the hospital. This could make it difficult for people to locate the appropriate place to attend for care.

We saw notice boards which displayed information regarding the staffing details of those who were on duty. This included staff names and colour coded tunics next to each staff member which reflected their designation. However, not all boards were updated every day. This could cause confusion for patients and their families/carers in identifying who was on duty and caring for them.

Some information was displayed on notice boards throughout the unit which highlighted areas of health promotion such as breastfeeding. However, there was little information regarding the health and wellbeing of mothers on the unit, such as post-natal mental health.

Information displayed was predominately available in English, with very limited available bilingually.

We saw that visiting hours were clearly displayed around the unit. Details were also contained within information leaflets which were given to patients upon their arrival.

Improvement needed

The health board must ensure that:

- Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards
- Notice boards containing information about staff on duty are updated at every shift change
- Notice boards are reviewed to provide health promotion information
- Information throughout the unit is made available bilingually.

Communicating effectively

Overall, patients who completed questionnaires and those that we spoke with seemed positive about their interactions with staff during their time in the unit. All patients agreed that staff were always polite, listened to them and were also polite to their friends and family. All patients agreed that staff had explained their birth options and any risks related to their pregnancy. All of the patients also agreed staff called them by their preferred name. Patient comments included:

> *"Despite being under enormous pressure and being very busy, everyone has been very polite and helpful."*

> *"All members of staff very friendly and supportive"*

We saw that staff on the wards met twice daily, at shift change over time. Midwifery and medical handovers were held separately due to their shifts not following the same 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.

We were told there is a health board maternity Facebook social media page which had been created to allow for support and communication with new mothers and sharing of experiences and feedback.

Each ward had a patient safety at a glance board[4]. We found these to be a good tool to communicate with staff across the unit. These were kept out of view of patients and visitors to protect patient confidentiality.

Timely care

We spoke to patients who told us that support was always available from staff in a timely manner. Patients said that all staff, including midwives, healthcare support workers and domestic staff were very helpful, attentive to their needs and provided support. We also saw that call bells were easily accessible.

During our inspection, questionnaires were also distributed to staff at the unit. A total of 55 questionnaires were completed. Staff told us that they do not always feel that they have enough time to care for patients due to time constraints and the complexity of some patient's needs. The majority of staff told us they were sometimes unable to meet all the conflicting demands on their time at work. Further reference to this is made in the 'workforce' section of the report.

We saw that patient observations were recorded in a recognised national chart to identify patients who may be becoming unwell or developing sepsis[5]. Staff were aware of the screening tool and reporting system for sepsis, and allowed for appropriate and timely action to be taken.

[4] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as, infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

[5] Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body's own tissues and organs.

Individual care

Planning care to promote independence

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 also saw that communication needs, including any need for interpreters or for information to be made available in other languages was assessed appropriately during antenatal appointments.

The hospital provided a chaplaincy service and there is a hospital chapel.

People's rights

We were told that the health board hold birth choice clinics, to promote the birth options available to patients and to provide information to help them make an informed decision. In addition, the consultant midwife told us that patients are provided with a letter of choices, which aids midwives when having discussions with patients about their care. We looked at a sample of patient care records and found limited documentation of discussions held with patients regarding their birth choices. Records of discussions with patients regarding their birth choices should be recorded so that their preferences can be supported effectively.

A patient information leaflet was also available for key aspects of pregnancy and labour to help women understand more about their birth choices.

Improvement needed

The health board must ensure that discussions with patients regarding their birth choices are recorded within patient documentation.

Listening and learning from feedback

The service had a process for addressing non-formal complaints, with the intention of resolving them at an informal level. 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. Staff told us that communication was maintained with patients and families throughout any concern received, and they were given the opportunity to meet with senior members of staff to discuss their concerns further.

We saw information leaflets and posters throughout the unit relating to the complaints procedure for patients to follow should they have any concerns they

wished to raise. We also saw information leaflets relating to the NHS (Wales) Putting Things Right[6] complaints procedure for patients, which provided clear information about how to raise any concerns they may have. This included details of the Community Health Council (CHC)[7] 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.

We spoke to the Patient Advice and Liaison Service (PALS) team based in the hospital. Their role was to ensure there was an emphasis on obtaining views about the care and services provided. They told us that any information obtained relating to the maternity unit was shared with the ward teams.

Nearly all staff who completed a staff questionnaire told us that patient experience feedback (e.g. patient surveys) was collected, however, only a minority said they received regular updates on the patient experience feedback. Half of the staff who responded said the feedback was used to make informed decisions within their directorate or department.

We saw feedback cards displayed on a board in the unit which allowed patients to write comments about their care and treatment received. The cards contained many positive comments provided by patients, expressing their thanks to the staff on the unit.

Contact details for the CHC were displayed on the board inviting patients to provide feedback on their experience in the unit. This would allow patients to give feedback confidentially should they wish to provide negative comments.

Improvement needed

The health board must consider the arrangements for how feedback is provided to staff.

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

[7] 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 a number of immediate concerns during the course of the 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 issues which included the following:

- The security of babies on the wards
- Irregular and inconsistent checks on emergency equipment
- Management and security of confidential patient and staff information
- Security and storage of medication on the unit.

We found there was a robust cleaning system in place for the birth pools. However, some midwifery and medical clinical policies and procedures were out-of-date and required review.

Safe care

Managing risk and promoting health and safety

Overall, the unit appeared to be clean and appropriately lit, however the environment was tired and in need of attention. This will be rectified with the opening of the new maternity unit. We found the midwifery led unit which had been refurbished was a pleasant, welcoming and homely environment.

The inspection team considered the security of new born babies on the postnatal ward. We found there were insufficient security measures to ensure that babies were safe and fully protected at all times. Reliance was placed on staff to establish who was entering or leaving the ward prior to operating a buzzer, or using their swipe card, to allow entry or departure from the ward. A closed circuit television camera at the entrance door to the ward captured images which were relayed onto a screen within the reception desk/nursing station of the ward,

however it only captured images of the top of a person's head. This meant that people could not be easily identified and there was a risk that a baby could be carried out of the unit by a mother or visitor without the knowledge of staff. The service was not using any other forms of security measures, such as electronic tagging, to ensure that babies were secure on the ward and to prevent baby abductions. This presented an immediate risk to the safety and security of new-born babies within the unit.

We saw that the potential risk of baby abduction at the hospital had been recorded on the health board's own risk register since June 2017. It was recorded that there was an increase in the risk as contractors working on the development of the new maternity ward were not all disclosure and barring service checked.

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

We were assured that a multi-disciplinary abduction drill had been carried out within the previous 12 months, in line with the health board's guideline.

Within the postnatal ward, we saw a cupboard door had been left unlocked and wide open, with hazardous cleaning materials left within easy access. This posed a risk of unauthorised access to hazardous substances. This was brought to the attention of the ward manager and action was immediately taken to rectify the situation. However during the course of the inspection, the door was found to be open and accessible on a further two occasions.

A long cable was seen to have been left plugged into the wall in the ward corridor. This could potentially cause a trip, electrocution or ligature hazard and posed a risk to patients and visitors. We informed staff who immediately removed the equipment, details of which can be found in Appendix A.

We looked at arrangements within the midwifery led unit for accessing emergency help and assistance in the event of a patient emergency as there was no direct phone line to the labour ward. We were not assured that help would be easily accessible in the event of an emergency. This meant there was a potential risk to patients and staff.

Improvement needed:

The health board must ensure the following:

- Cupboard doors containing hazardous materials remain locked to prevent unauthorised access
- Consider how emergency help can be obtained from the midwifery led unit if required.

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 for 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.

Falls prevention

We spoke to staff who told us that any patient falls would be recorded on the health board incident reporting system and any lessons learnt acted on appropriately.

Infection prevention and control

Overall, we found the clinical areas were clean and tidy, however the furnishings and fittings were generally in a poor state of repair. We saw that some areas of flooring were taped together and wallpaper was coming away from the walls due to the poor general infrastructure of the maternity unit. Whilst all of the bathrooms were noted to be clean, the majority were in need of updating.

We saw that regular infection control audits were being undertaken and were shown the results. We found that cleaning schedules for the unit were in place, however, there were inconsistencies noted in their completion by domestic staff.

Infection prevention control training was mandatory for staff. Most staff indicated in their questionnaires that they had undertaken learning and development, in infection control prevention in the last 12 months. Further reference to compliance with mandatory training is referred to in the 'workforce' section of this report.

The inspection team saw that personal protective equipment (PPE) was available in all areas and was being used by all healthcare professionals.

Hand washing and drying facilities were available, together with hand hygiene posters, and hand washing guides which were displayed in patient toilets. Hand gel dispensers were full and readily available on the wards and at the end of the beds.

We saw that there were robust cleaning systems in place for the birth pools which included when the pools had not been used. The cleaning pathway was located by the birth pools and clearly visible for staff to see. This ensured that the birthing pools were appropriately cleaned and safe to use.

The inspection team observed that the doors to the operating theatre on the labour ward had been left wide open. This posed a risk as the area could become contaminated. Doors in clinical areas were also seen to be wedged open. We recommended that theatre doors and doors to clinical areas are securely closed to to demonstrate a good commitment to infection prevention and control.

We saw that some of the curtains in the unit were made of washable fabric. We advised that all curtains within the unit should be disposable, meaning that they could be easily replaced should they become contaminated or dirty.

The service had an en-suite room available for patients use should there be a requirement for barrier nursing, to help prevent infections being transferred to other patients.

During the inspection, we observed a few members of staff not upholding the standards of bare below the elbow[8]. We saw staff wearing wrist watches, a nose ring and extra ear piercings.

[8] 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), or wrist watches, nail polishes or false nails.

Improvement needed

The health board must ensure the following:

- Consistent completion of cleaning schedules
- Doors to the theatre department and all clinical areas are kept closed
- Fabric curtains are replaced with disposable curtains
- All staff are reminded of the bare below the elbow policy.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met throughout the day and night. We saw patients being offered hot and cold drinks and had access to jugs of water within easy reach. We saw that patients were given a choice of food, however, some patients told us that the choice was limited and that the hot food was served tepid or warm. Most patients told us the meals were not very good or appetising.

Staff told us that the unit were able to access a regular supply of food for patients whenever required.

One patient who had specific dietary requirements told us that midiwives had gone out of their way to ensure that appropriate food was available for her.

Improvement needed

The health board must ensure that patient's nutritional needs are met by providing access to a good choice of nutritious food served at the appropriate temperature.

Medicines management

The inspection team saw that the ward managers carried out monthly medicine management audits to help ensure standards were maintained. However we found improvements were required with regards to areas of medicines management across the unit.

We considered the arrangements for the safe storage of medications throughout the unit and found there were a number of areas where medication was not being

securely stored to prevent unauthorised access and to uphold patient safety. This included the medicines cupboard in the postnatal ward which was not locked and medication was accessible on shelves. We also saw lignocaine[9] had been left on a trolley in the antenatal ward and the medicines room was unlocked, with adrenaline left out and the fridge unlocked. The medicines fridge in the midwifery led unit was also unlocked.

Our concerns regarding the above issues were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Dedicated pharmacy support was available to the unit with details of the contact details for the out of hours provision clearly displayed on the ward. This would ensure there was no delay in patients receiving medication.

Safeguarding children and adults at risk

We saw that the health board had policies and procedures in place to identify, promote and protect the welfare of children and adults who were vulnerable or at risk. The service had a lead safeguarding midwife for the health board.

During a review of a sample of antenatal medical notes, we saw that safeguarding issues had been highlighted and sensitively addressed with clear and open discussions taking place with patients. This ensured that appropriate procedures were in place to alert staff to safeguarding concerns with regards to patients being admitted onto the wards, to ensure care and treatment was provided in an appropriate way.

Safeguarding training was mandatory for all midwives within the unit. 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 where necessary.

Medical devices, equipment and diagnostic systems

The inspection team considered the arrangements for the checking of emergency equipment throughout the unit. We found that checks of equipment used in a

[9] A local anaesthetic drug.

patient emergency were insufficient as they were not recorded as being carried out on a daily basis. We found this in relation to the following equipment on the labour ward and the midwifery led unit:

- Neo-natal resuscitaires[10]
- Emergency resucitation trolley.

We raised this immediately with representatives of the senior management team who confirmed these checks should be carried out daily.

Our concerns regarding the above issue were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Effective care

Safe and clinically effective care

Based on our immediate concerns identified during the course of the inspection, we were not assured that patient care could always be provided in a safe and effective way. This was because of inconsistent checks of emergency equipment, insufficient security measures in place to fully protect babies on the postnatal ward, and medication not being securely stored to prevent unauthorised access and to uphold patient safety. However, it was positive to find that staff reacted quickly and promptly to address the issues we raised.

The inspection team considered the availability of a 24 hour on-call obstetrician. We were assured by staff, and observed, that appropriate criteria was in place for calling in a consultant obstetrician out of hours. We also saw there were two resident operating department practitioners (ODP), one of whom was dedicated 24 hours a day to the maternity unit. In addition, a neonatal service was provided at all times to provide specialist care for newborn babies. We considered these to be areas of good practice.

[10] Equipment used in the resuscitation and clinical emergencies of babies

Quality improvement, research and innovation

We saw that good initiatives had been introduced by the consultant midwife which included birth choice clinics. These provide women with an opportunity to explore their birth choices and provide them with information in a balanced, understandable and individualised way. We saw that positive feedback had been received from patients who had attended these clinics.

We also saw further good work carried out by the consultant midwife to achieve expert practice in the development of the new Vaginal Birth After Caesarean Section (VBAC) protocol. This had resulted in a positive outcome with an increase in the overall rate of attempted VBAC. Further positive outcomes had been achieved by the unit with an increase in the number of home births seen.

The unit currently has access to a nurse to provide support for perinatal mental health from a mental health nurse; however we were told that measures were 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.

The health board have two part time breastfeeding co-ordinators and the breastfeeding uptake was reported as being at a high level.

Information governance and communications technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations (2018) within the unit. We found within the post-natal ward and labour ward that patient information was not being managed or stored to prevent unauthorised access and to uphold patient confidentiality. This included patient identifiable information noted within a book in a treatment room and details of births left accessible within an unlocked room. We also saw patient identifiable information which had been left in a blood gas machine on the sample bottle. In the office within the labour ward, drawers had been left unlocked and details of staff sickness levels, return to work documentation and staff telephone numbers were found to be easily accessible. We also saw numerous birth registers which contained patient information in an unlocked storeroom within the entrance to the antenatal ward.

Our concerns regarding the above issue were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and guidelines. However, some of this information was found to be out-of-date and requiring review. We were told by senior managers that all policies and guidelines were currently under review and the process will be completed by December 2019. We also saw some guidelines were accessed in paper form with printed copies available for reference. We considered this to be a risk as there may be more recent versions available containing updated information and guidance.

Some staff we spoke to told us that they were unaware of how to access guidance and policies on the health board's intranet. We recommended that steps were taken to ensure that all staff have the knowledge of how to access guidance and policies on the intranet to enable them to retrieve and review and use all policies.

Improvement needed

The health board must ensure that:

- All midwifery and clinical policies/procedures are reviewed and updated within appropriate timescales
- All policies and guidelines are accessed from the health board's intranet to ensure the latest version is referred to
- All staff have the knowledge of how to access guidance and policies on the health board's intranet.

Record keeping

We considered a sample of patient records within the unit and found them to be disorganised, difficult to navigate and the writing illegible at times. However, we saw that the health board had recently introduced new patient maternity booklets, which inlcuded separate booklets for antental inpatient record, induction of labour and postnatal care. This will mean that patient records will be easier to navigate in the future.

Whilst we saw evidence of well documented multidisciplinary care plans, improvements could be made to patient records to include the following areas:

- VTE[11] assessments not correctly filled in
- Discussions with patients regarding their birth choices should be fully documented
- Inconsistencies and gaps in signatures and General Medical Council registration number completion
- Growth scans not plotted on GAP/GROW[12] chart
- Poor documentation by obstetricians. Patient notes updated by midwives when patients had been reviewed by a consultant.

The inspection team saw that Modified Early Obstetric Warning System (MEOWS)[13] charts completed in patient records remained in colour coded format and had not been photocopied. The colour coding assists in identifying when a patients condition has deteriorated and their care needs to be escalated.

Improvement needed

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

[11] Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs

[12] 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

[13] A MEOWS chart improves the detection and response to clinical deterioration in pregnancy and is a key element of patient safety and improving patient outcomes

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

A lead midwife for clinical risk and governance was in place who held responsibility for reviewing, investigating and managing clinical incidents. We found a robust process in place for managing incidents.

However, we found inconsistencies in staff compliance with statutory and mandatory training for all healthcare professionals at all levels. In addition, staff reported low morale and well-being amongst the staff teams.

Governance, leadership and accountability

The service had in place a number of regular meetings to improve services and strengthen governance arrangements. Such meetings included monthly clinical risk meetings which were held at Glangwili Hospital where reported incidents, investigations and their findings were discussed in a multidisciplinary format. Matters discussed at these meetings would be distributed to staff via the monthly labour ward forum, perinatal mortality meetings, unit meetings and consultant meetings.

Monthly quality, safety and patient experience meeetings took place, following which key findings from the investgations and reviews were included in the maternity risk management newsletter to communicate any themes and trends to staff. The inspection team considered the maternity risk management newsletter to be an excellent 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.

We spoke to, and received comments in the staff questionnaires, from band 6 midwives who reported feeling ignored and expressed that there was no forum for staff at their level to meet and have discussions.

A lead midwife for clinical risk and governance was in place who held 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.

Medical staff we spoke with were confident with the process for recording incidents. They said that all required serious cases were fully investigated and efforts were made to ensure there was no conflict of interest with the consultant input on investigations. One member of medical staff spoke positively of attending a recent labour ward forum where feedback was given following the investigation of a serious incident.

Most staff that we spoke to or who completed questionnaires said that the organisation encourages them to report errors, near misses or incidents.

Around half of the staff who completed questionniares agreed they were informed about errors, near misses and incidents that happen in the organisation, and that they were given feedback about the changes made in response. They reported a robust system for investigating and reporting incidents. However, a minority of staff said that the organisation would blame the people who are involved in such incidents. Staff comments included reference to a blame culture existing on the unit. A recommendation regarding improvements in communication within the unit between senior managers and staff is made in the ‘workforce’ section of this report.

We saw that there was a good level of oversight of clinical activities and patient outcomes. The unit was using a maternity dashboard which is an electronic tool to monitor the clinical performance and governance of their services. This provided information with regard to clincal activity on the wards, 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 assosicated with the numbers and figures. The dashboard was updated monthly and discussed at the labour ward forum and the quality, safety and patient experience meetings.

We found that there was insufficient audit activity being carried out on the ward, to ensure that essential activities were being undertaken. This is demonstrated by findings earlier in this report, which include the following:

- Daily checks on emergency equipment
- Safe storage of medications throughout the unit
- Arrangements for security of patient information
- Cleaning arrangements for the wards.

We were not assured that there was sufficient oversight by the management of the wards to be confident that there was a robust process in place for audit activity, to help demonstrate a safe and effective service.

We were told that the consultant midwife was involved in audits of the outcomes of clinics which included the VBAC clinic, raised body mass index clinic, gestational diabetic clinic, and declining induction of labour clinic. A report of the audits was prepared and presented to the labour ward forum.

Improvement needed

The health board must ensure that:

- There are robust audit processes in place for ward activities, and that there is sufficient oversight of this within the health board.

Staff and resources

Workforce

We were told by senior managers that the unit was not currently compliant with birth rate plus[14], however, they were in the process of recruiting midwives and healthcare support workers which would ensure their compliance. We were

[14] Birthrate Plus is a midwife planning tool that provides a comprehensive assessment of the staffing needed to provide the care required by a woman in maternity services.

informed that the posts had been advertised on TRAC[15]. Senior managers said that staffing levels within the unit were being managed through the use of community midwives being called in, internal bank staff and the goodwill of the current establishment performing additional shifts, to maintain minimum staffing levels. We also saw there was a maternity escalation process and regular recording and monitoring of daily acuity in place to ensure that staffing levels and staff location on the wards were monitored.

Senior managers told us that nine midwives should be on duty within the unit, however we noted in the minutes of a maternity core staff meeting that it was suggested that the total should be ten. The inspection team reviewed the midwifery rota and noted there were occasions when there were not ten midwives on duty within the unit. We were not fully satisfied that shifts were appropriately staffed to ensure that services could be maintained safely and effectively.

Staff who we spoke to, and those who completed questionnaires, commented that the unit was regularly understaffed. Around two thirds of staff who completed a questionnaire felt there were only sometimes enough staff at the unit to enable them to do their job properly, whist a few said that there were never enough staff. Staff also referred to difficulties in taking breaks, feeling stressed due to work, and the unit being run on the goodwill of staff. Some of the comments received from staff were as follows:

> *"Due to staff shortages on many shifts morale appears generally low. Shifts are mostly overwhelming - demand for the service on most occasions overwhelms its capacity of the unit and staffing - compromising safety. Breaks on shifts are a rare occurrence- some managers are very proactive at ensuring staff have breaks."*
>
> *"I feel we are unable to provide efficient care to our patients during busy periods due to staff shortages."*

In light of the concerns received from some staff regarding low morale due to staffing levels and working pressures due to patient acuity, we recommend that

[15] NHS recruitment system.

senior management review staffing rotas. This will ensure that staffing levels are appropriate to the provision of safe and timely care.

We spoke to senior managers who were of the view that staff on the unit were generally happy and supportive of each other and that it was a nice place to work. Senior managers said they were present on the unit and were open and visible to staff. They said there was management support for the overall workforce and they all worked closely together in a small unit.

We were told that changes had been made in annual leave allocation and shift patterns to provide a fairer, more consistent approach for all staff. They said that the changes had resulted in a negative impact on staff morale.

Staff were asked questions about their immediate manager, and the feedback received was generally positive. Nearly all staff who completed a questionnaire said that they know who the senior managers were in the organisation however, they felt that communication between senior management and staff was not effective. Some comments recevied were:

> *"I sometimes feel that senior managers are not aware of what happens on the shop floor and often take a snapshot of what's happening but doesn't reflect the real work environment"*

> *"There is very poor communication between senior management and staff and senior management are very rarely visible during the day."*

We recommended that senior management should explore the reasons for low morale and well-being amongst the staff teams. Based on the feedback from staff, there is also a need for improvements in communication within the unit.

Whilst the inspection team noted that staff morale was low, we were reassured to establish that this had not had a negative impact on the patient experience within the maternity unit. This demonstrated the commitment and professionalism of staff to the patients, their role, the unit, and the health board.

The inspection team found that, whilst morale amongst midwifery staff was low, this was not the case amongst medical staff. We spoke to medical staff of all grades and found that morale was good. We were told that this was also reflected in a junior doctor GMC survey results.

The health board had two clinical supervisors of midwives in place. Their role was to provide support and professional supervision to midwifery staff. Neither

were available to speak to us during the inspection however, staff we spoke to said that they were satisfied with the level of clinical supervision received.

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 PROMPT[16] 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 CTG masterclass.

In addition, we saw that staff were required to complete mandatory E-learning which included infection prevention and control and safeguarding. 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.

We reviewed staff compliance with statutory and mandatory training and identified inconsistencies in compliance for all healthcare professionals at all levels including midwives, healthcare support workers, medical staff including consultants and management staff. We found that this could impact on the provision of safe care to patients.

Our concerns regarding the above issue were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

The training portfolio also referred staff to discussion forums which they were invited to attend. This included the labour ward forum, perinatal meetings and antenatal and postnatal forums.

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

Most staff 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. A few staff highlighted they would benefit specifically from newborn examination training.

The majority who completed a questionnaire said the organisation always or usually encouraged teamwork. Around half who answered felt the organisation was always or usually supportive, and very few answered never.

We spoke to theatre staff who reported good communication between anaesthetists and consultants. We saw that one theatre was dedicated to the labour ward and we were assured that patients would be transferred to the main hospital theatre in the event of an emergency if the labour ward theatre was being used.

Medical staff that we spoke to reported good working relationships amongst the medical team.

Improvement needed

The health board must ensure that:

- A review of staffing rotas is undertaken to ensure that staffing levels are safe and effective to meet the needs of the service
- The reasons for low morale and well-being amongst the staff teams are explored
- A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication
- Consideration is given to the provision of additional training for 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
We found that a long cable from a piece of equipment had been left plugged into the wall in the ward corridor.	This meant that there was potential for patients and visitors to trip, be electrocuted or use the cable as a ligature.	We raised this immediately with senior managers.	The lead was immediately removed.

Appendix B – Immediate improvement plan

Hospital: Glangwili General Hospital

Ward/department: Maternity Services

Date of inspection: 7, 8, 9 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 is required to provide HIW with details of the action it will take to ensure that: Measures have been put in place to ensure that babies are safe and secure across its maternity services to prevent baby abductions.	2.1 Managing Risk and Promoting Health and Safety 2.7 Safeguarding Children and Safeguarding Adults at Risk	•To contact estates department to adjust CCTV camera angle. • To obtain a wide angle and full length picture of personnel entering and leaving the postnatal ward area. • To contact estates in order to install an additional security camera in the internal corridor to monitor staff and patients exiting postnatal ward. • To establish a schedule of abduction drills with outcomes discussed at Directorate Quality and Safety. To commence October 2019.	Head of Midwifery Head of Estates Head of Estates Head of Midwifery	14 October 2019 18 October 2019 11 October 2019 14 October 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• Frequency of above Baby Abduction Drill audit to be reviewed following full implementation of Baby tagging system.	Head of Midwifery	31 January 2020
		• Baby tagging system to be installed week commencing 21/10/19 to reduce risk of baby abduction on the postnatal ward. (This is part of phase 2 development).	Head of Estates	21 October 2019
		• To review Directorate Risk Register following results of Baby Abduction Audits.	Head of Midwifery	30 November 2019
		• To remind all staff regarding vigilance when staff, contractors, visitors along with patients enter and leave of clinical areas. This will be undertaken via the Clinical Risk Newsletter, Safety Brief, handover sheet, and Hot File.	Head of Midwifery	Completed
		•All external meetings scheduled for Dinefwr seminar room in clinical area to be cancelled.	Head of Midwifery	Completed

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. • 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 safety brief, ward 'Hot File' and Risk Newsletter.	Head of Midwifery Head of Midwifery Head of Midwifery	18 October 2019 18 October 2019 Completed
The health board is required to provide HIW with details of the action it will take to ensure that: Medication across the unit is stored safely and securely at all times.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	•Lock to be replaced onto door entering medication store room. • To arrange meeting with Medicine Management Lead for HDUHB to review current environmental processes and ascertain whether any additional assurances can be	Head of Estates Head of Midwifery	Completed Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		implemented within the clinical areas. • Staff to be reminded regarding importance and requirements for closing medicine cupboard door and compliance to medicine management policy via 'Hot File' and Risk Newsletter. • To circulate Medicine Management Policy to all midwifery staff via NHS Wales emails. • To conduct weekly assurance audit to provide external scrutiny.	Head of Midwifery Head of Midwifery Head of Midwifery	Completed Completed Completed
The health board must provide HIW with details of the action it will take to ensure that: There are appropriate systems in place to maintain the security and confidentiality of patient and staff information at all times, in order to prevent unauthorised access.	3.5 Record Keeping	• To circulate Information Governance policy to all midwifery staff via NHS Wales emails. •To ensure all staff have completed the mandatory governance training annually. • To contact Public Health Wales Antenatal Screening regarding	Head of Midwifery Head of Midwifery Head of Midwifery	Completed 31 March 2020 Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		adherence to Information Governance policy within HDUHB. • To contact Bounty regarding adherence to Information Governance policy within HDUHB. • All staff to be reminded of ensuring patient and staff's confidential information is stored confidentially and not left unattended within any open areas and open offices. • To establish an audit schedule which includes compliance with information governance.	Head of Midwifery Head of Midwifery Head of Midwifery	Completed Completed Completed
The health board must provide HIW with details of the action it will take to ensure that: There is consistency in compliance for statutory and mandatory training, including manual handling training for birthing pool evacuation, for all healthcare professionals at all levels.	7.1 Workforce	• To discuss with manual handling trainer the formal recognition of the in-house training by the Band 7 Midwifery led Coordinator for the Midwifery led Care Unit. • To share the HDUHB Standing Operating process which is compliant with Midwifery Led Care	Head of Midwifery Head of Midwifery	Completed 18 October 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		and adheres to the All Wales Midwifery Led Care Guidelines on Water births via Clinical Risk Newsletter.		
		• HDUHB Standing Operating process for Water births to be available via the HDUHB intranet under policies and guidelines.	Head of Midwifery	30 November 2019
		•HDUHB Standing Operating process for evacuation form a birthing pool to be in all delivery rooms where women access water birth.	Head of Midwifery	Completed
		• Evacuation drills to be conducted monthly with all staff working within a midwifery led Unit. These will be recorded and shared at the Directorate Quality & Safety Meeting.	Head of Midwifery	31 January 2020
		To review and audit maternity training database to demonstrate that all staff are completing maternity specific training annually.	Head of Midwifery	31 January 2020

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		To routinely share compliance of maternity training audit at Directorate Quality and Safety Meeting	Head of Midwifery	31 January 2020

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): Lesley Owen

Job role: Deputy Head of Midwifery

Date: 16 October 2019

Appendix C – Improvement plan

Hospital: Glangwili General Hospital

Ward/department: Maternity Services

Date of inspection: 7, 8, 9 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 must: • Consider how the privacy of patients can be maintained if staff have discussions in the open plan bay area	4.1 Dignified Care	Staff reminded of the importance of maintaining patient's dignity and respect and overall confidentiality. Consideration given to using alternative areas for discussion when available to promote confidentiality	Head of Midwifery & Women Services	30 March 2020 31 January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Consider gaining patients' views regarding visiting access of birthing partners.		Consideration to be given to closing curtains, if acceptable to women Communication relating to privacy and meeting patient's needs in open plan spaces to be disseminated to all staff via Clinical risk newsletter, team meetings and staff briefings Patient feedback questionnaire to be designed to collect patient views on birthing partners staying overnight		31 January 2020 31 January 2020 30 March 2020
The health board must ensure that: • Signage at the hospital is reviewed to ensure that it is easy for patients to locate all of the maternity wards	4.2 Patient Information	To discuss with Head of Estates department the maternity signage across Glangwili General Hospital	Head of Midwifery & Women Services Head of Estates	31 May 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Notice boards containing information about staff on duty are updated at every shift change • Notice boards are reviewed to provide health promotion information • Information throughout the unit is made available bilingually.		Notice boards to be updated on a shift by shift basis illustrating staff on duty by shift leader Ward manager in each maternity ward to lead on health promotion information on the notice boards Clinical lead to meet with Head of Welsh Language services to discuss appropriate information being available in Welsh	Head of Midwifery & Women Services Head of Midwifery & Women Services Head of Midwifery & Women Services.	Complete 31 March 2020 31 March 2020
The health board must ensure that discussions with patients regarding their birth choices are recorded within patient documentation.	6.2 Peoples rights	Staff to be reminded of the importance of ensuring 'Birth Choices' is documented in All Wales Handheld Record at Booking and during pregnancy. Importance of documenting 'Birth Choices' to be included in the Maternity Risk Newsletter Audit to be undertaken on compliance of completed 'Birth Choices' documentation in the All Wales Handheld record	Head of Midwifery & Women's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services	31 January 2020 31 January 2020 31 March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must consider the arrangements for how feedback is provided to staff.	6.3 Listening and Learning from feedback	Information to be disseminated via Management Meetings, Team Briefs and via the Clinical Risk Newsletter Individual feedback provided by Operational Lead Midwife and Band 7 Team Leaders Table top discussions held with staff involved with any clinical incident and staff are supported by clinical supervisor for midwives to ensure reflective practice and lessons are learnt Sharing of lessons learnt are communicated via Labour Ward Forum, Staff Forums, Clinical Risk Newsletter, Staff briefings, Notice Boards and Unit Meetings	Head of Midwifery & Women's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services	31 January 2020 Complete Complete Complete
Delivery of safe and effective care				
The health board must ensure the following: • Cupboard doors containing hazardous materials remain locked to prevent unauthorised access	2.1 Managing risk and promoting health and safety	All maternity and Hotel Services Staff to be reminded to keep all doors locked. New key pad to be added to doors as extra control measure.	Head of Midwifery & Women's Services.	Complete Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Consider how emergency help can be obtained from the midwifery led unit if required.		Emergency help is accessed via the hospital fast bleep system and direct telephone contact with labour ward in line with other alongside MLU'S in Wales All staff on MLU to be reminded of procedure	Head of Midwifery & Women's Services Head of Midwifery & Women's Services	Complete Complete
The health board must ensure the following: • Consistent completion of cleaning schedules • Doors to the theatre department and all clinical areas are kept closed • Fabric curtains are replaced with disposable curtains	2.4 Infection Prevention and Control (IPC) and Decontamination	Hotel Services and Midwifery staff reminded to adhere to cleaning schedules Audits of cleaning schedules incorporated into the monthly ward assurances process Staff reminded to keep doors shut at all times and signage placed on all doors HOM to meet with Laundry Lead to explore purchasing of disposable Curtains for clinical areas	Head of Midwifery & Women's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services	Complete Complete Complete 31 March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• All staff are reminded of the bare below the elbow policy.		All Staff have been reminded to adhere to the bare below the elbow policy in line with infection control procedures Compliance monitored via monthly infection control audits conducted by ward managers All staff to be challenged if non-compliant with uniform and infection control policy	Head of Midwifery & Women's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services	Complete Complete Complete
The health board must ensure that patient's nutritional needs are met by providing access to a good choice of nutritious food served at the appropriate temperature.	2.5 Nutrition and Hydration	Meet with the Head of catering services to discuss food choice and temperature of food for women on the maternity unit Annual audit on food choice to be captured through Fundamental of care audits	Head of Midwifery & Women's Services Head of Midwifery & Women's Services	31 January 2020 31 January 2020
The health board must ensure that: • All midwifery and clinical policies/procedures are reviewed and updated within appropriate timescales	3.4 Information Governance and Communications Technology	All operational / clinical policies to be updated by 31 December 2019	Head of Midwifery & Women's Services	31December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
• All policies and guidelines are accessed from the health board's intranet to ensure the latest version is referred to • All staff have the knowledge of how to access guidance and policies on the health board's intranet.		All staff reminded regarding accessibility of all policies via HDUHB Intranet and WISDOM Guideline for accessing policies via the HDUHB intranet site has shared with all clinicians via flow chart on all computers within the maternity department	Head of Midwifery & Women's Services Head of Midwifery & Women's Services	Complete Complete
The health board should ensure that patient records are fully reflective of the care and standard provided to patients and 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's Services Head of Midwifery & Women's Services Head of Midwifery & Women's Services	Complete Complete Complete
Quality of management and leadership				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that: • There are robust audit processes in place for ward activities, and that there is sufficient oversight of this within the health board.	Governance, Leadership and Accountability	Operational Lead Midwife from different clinical area to conduct a 15 step challenge audit at Glangwili General Hospital to provide independent assurance Board to Floor visits conducted by the Executive Board Team with Independent Board member's to gain assurance in respect of quality and safety of service provision	Head of Midwifery & Women's Services Head of Midwifery & Women's Services Chair of Quality and Safety Board	Complete Complete
The health board must ensure that: • A review of staffing rotas is undertaken to ensure that staffing levels are safe and effective to meet the needs of the service	7.1 Workforce	Rosters reviewed on a monthly basis to ensure equitable safe rostering. E-roster manager to conduct independent audit on compliance against e roster guidelines	Head of Midwifery & Women's Services/Clinical Lead Head of Midwifery & Women's Services	Complete Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Workforce Tool, Birthrate Plus to be undertaken in 2020 to review staffing requirements for maternity	Head of Midwifery & Women's Services	30 September 2020
The reasons for low morale and well-being amongst the staff teams are explored		HOM and senior managers to meet with all staff to understand the issue for low morale within the department.	Head of Midwifery & Women's Services	31 March 2020
		NHS Staff survey to be undertaken	Head of Midwifery & Women's Services	30 April 2020
A review of the adequacy of communication channels between senior managers and staff is undertaken to ensure effective communication		Monthly open surgeries for staff to meet with senior managers	Head of Midwifery & Women's Services	31 January 2020
Consideration is given to the provision of additional training for midwives.		Review additional training requirements via training needs analysis and PADR process	Head of Midwifery & Women's Services	30 April 2020

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 & Women's Services

Date: 5 December 2019