Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Prince Charles Hospital – Maternity Services, 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 are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Prince Charles Hospital within Cwm Taf Morgannwg University Health Board on 4, 5 and 6 November 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:

- Ward 21 - antenatal ward (before delivery) and postnatal ward (following delivery) with a capacity of 24 beds
- Midwifery led unit - with a capacity of three birthing rooms and two birthing pools
- Labour ward - (during labour) with a capacity of four delivery rooms and one birthing pool
- Triage assessment area
- Two operating theatre.

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

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 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. This included ensuring that there was sufficient oversight of the day to day activities on the wards.

This is what we found the service did well:

- Women and their families were positive about their care and treatment
- We observed professional and kind interactions between staff and patients and we saw care provided in a dignified way
- Arrangements were in place to provide women and families with bereavement and perinatal support
- Strong midwifery leadership and good support offered to staff.

This is what we recommend the service could improve:

- Regular checking of resuscitation equipment for newborn babies and adult patients
- Mitigation of risks around baby abduction
- Review of induction of labour medication prescribing
- Storage of medicines
- Review of policies and procedures
- Some areas of patient record keeping
- Availability of smoking cessation information throughout the unit.

3. What we found

Background of the service

The Prince Charles Hospital is located in Merthyr Tydfil 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 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. 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.

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

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

[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 were positive about their overall experience of the service and felt they had always been treated with dignity and respect.

We observed polite, friendly and supportive interactions between staff and patients. We saw care was provided in a way that upheld patient dignity. However, antenatal/postnatal bed allocation needed to be reviewed to maintain dignity and respect of patients during care.

During the inspection, we attempted to distribute HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided. However, we were advised that the Patient Advice and Liaison Services (PALS) team based in the hospital had already conducted interviews and completed questionnaires with patients on the unit on the day of our arrival. To avoid patients completing another similar questionnaire, we were given the data obtained from the PALS team to review. A total of nine questionnaires were completed.

Patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent or very good. Patients and their families who we spoke with said they had a good experience in the whole of the unit. Patient comments included the following:

> *"I would recommend the maternity unit this time it has improved greatly since the birth of my child 5 years ago".*

> *"Staff and midwives have been fantastic throughout".*

All of the patients who completed a questionnaire agreed that they were able to speak to appropriate staff about any worries and fears they may have.

Staying healthy

We saw adequate information displayed for patients on notice boards and leaflets were readily available to inform patients of how they can stay safe and healthy. Although the hospital was a designated no smoking zone which extended to the

use of vapour/e-cigarettes, we saw little information in relation to smoking cessation throughout the unit.

There was informative health promotion displayed in relation to breastfeeding, pain relief in labour, skin to skin advice, post-natal mental health and general advice on keeping healthy before, during and after pregnancy. We were told by staff we spoke to that there was well established perinatal mental health support available if needed.

We saw a plaque on the wall stating the unit was UNICEF[4] baby friendly accredited in 2017. Accreditation is reviewed every three years which confirms 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 witnessed many examples of staff being compassionate, kind and friendly to patients and their families. We saw staff treating patients with respect, courtesy and politeness at all times. Staff were seen to take the time to support patients when required.

We saw staff promoting privacy and dignity when helping patients with their personal care. We reviewed care documentation and did not find any areas of concern regarding dignified care. However, we saw one occasion where bed shortages were reported on the antenatal and postnatal wards. As a result, patients would be inappropriately allocated to beds within unsuitable areas such as pregnant patients placed within bays where patients and their babies were being cared for.

[4] 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.

There were en-suite facilities within some of the birthing and postnatal rooms which helped promote patients' comfort and dignity during their stay. Where en-suites facilities were not available, shared toilet facilities were available nearby.

The majority of the staff we spoke to advised that they had received training in bereavement and would feel confident in accessing the correct policies to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit. We saw this provided a suitable environment for patients and families to use. If this room was in use, we were told that an unoccupied postnatal room would be made available. We were told there was a lead bereavement midwife who worked across the health board to offer support and advice during core working hours. Some staff raised concerns regarding the wide geographical coverage for a single lead to support all maternity sites. However, we were given assurance that the bereavement lead was introducing band five midwives into the newly created support role of bereavement champions within Prince Charles Hospital to ensure further support and guidance is available.

Improvement needed

The health board must ensure that bed allocation within the antenatal and postnatal wards is reviewed to ensure that patient dignity is maintained.

Patient information

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

Daily staffing details of the unit were displayed within the unit to inform patients of who would be caring for them.

Information was predominately available in English, with limited information in Welsh. We were told there was a rolling programme in place to ensure that all information was bi-lingual and current information was in the process of being translated. Staff we spoke with were aware of the translation services within the

health board and how they were able to access these. Welsh speaking midwives were identifiable by the Welsh speaker logo[5] on uniform or lanyard.

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire said they felt confident to ask for help or advice when assistance was required. The majority of patients also shared that they had been listened to by midwifery and medical staff during their stay.

We saw that staff tried to maintain patient privacy throughout the unit when communicating information. However, we saw there was limited privacy within the antenatal and postnatal bays due to the small size, which meant any confidential conversations held in these bays could be easily overheard by others. We did however notice that it was usual practice for staff to close doors of consultation rooms when providing care to protect patients' privacy and dignity.

We saw that staff within the unit met twice daily, at shift change-over time. At the full multi-disciplinary handover meetings we attended, we found the process to be unstructured and interrupted on a number of occasions. Patient handover information was not seen to be actively captured or logged and there was no evidence of an attendance sheet being consistently used. However consultant attendance was seen and midwifery attendance was also good.

Each ward had a patient safety at a glance board[6] which were found to be consistently updated.

The use of language line was available for those patients whose first language was not English, meaning they were able to access care appropriate to their needs. We also saw that communication needs, including any need for

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5 The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying the Welsh speakers on your team. If someone is wearing a badge, or lanyard, this shows that they can have a conversation in Welsh.

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

interpreters or for the information to be made available in other languages was assessed appropriately during antenatal appointments.

Improvement needed

The health board must ensure that the process and structure of multi-disciplinary handover meetings are reviewed and improved.

Timely care

We saw that staff were very helpful and would attend to their needs in a timely manner. We were also told by staff that they would do their utmost to ensure patients were regularly checked for personal, nutritional and comfort needs. This was seen within the patient's records we reviewed. We also saw that call bells were seen to be easily accessible and answered promptly.

We saw that patient observations were recorded on a recognised national chart to identify patients who may becoming unwell or developing sepsis[7]. Staff were aware of the screening tool and reporting system for sepsis, which allowed for appropriate and timely action to be taken.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit.

We looked at a sample of patient records within the unit and found evidence that patients' personal beliefs and religious choice were captured during antenatal appointments. This was to ensure they were upheld throughout their pregnancy, labour and postnatal care. We saw that care plans promoted people's independence based on their assessed abilities.

[7] 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.

We found that medical and midwifery staff promoted individual care and choices for patients. Birthing partner support was also promoted. All of the birthing rooms were well equipped. Three birthing rooms had a plumbed in birthing pool which patients could use during labour.

People's rights

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

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

Listening and learning from feedback

Information was available on the health board's website relating to the procedure for patients to follow should they have concerns they wish to raise, however there was little information available on the unit for patients. We were told by the senior management team that ward managers within the unit were fully aware of the NHS process for managing concerns - Putting Things Right[8] and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints but that they did not routinely provide patients with details of the Community Health Council (CHC)[9], who could provide advocacy and support to raise a concern about their care.

We were told that following an informal complaint, lead matrons would contact the patient offering to discuss their issues, as well as promoting the formal complaint procedure should they wish to follow this route. Staff explained that this was used as a way of addressing concerns, but also to highlight any practice issues that may need resolving. Staff told us that communication was maintained with patients and families throughout any concern received and they were given

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

[9] http://www.wales.nhs.uk/sitesplus/899/home

the opportunity to meet with senior members of staff to discuss their concerns further.

We spoke to the PALS team who advised that their role was to ensure there was an emphasis on obtaining views on the care and services provided. The team explained that any information relating to the maternity unit was shared with the ward teams.

Staff told us that they regularly seek patient feedback through feedback cards or questionnaires one of which is the 'have your say' comments card which is given to all women following birth. These are acted upon by the senior management team and shared with staff during lessons learnt meetings and appraisals.

Improvement needed

The health board must ensure that:

- Information is clearly displayed and readily available about how patients and families/carers can raise a concern about their care
- Patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

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 nine 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 regarding the checks of resuscitation equipment, secure storage of medication, mitigation of baby abduction risks within the unit, inconsistent monitoring of fetal heart rate, security of patient records and concerns regarding induction of labour medication prescribing.

We also identified areas for improvement regarding infection prevention and control.

We found patient safety was promoted in daily care planning and this was reinforced within the patient records we reviewed.

The service adhered to appropriate arrangements for safeguarding procedures, including the provision of training.

Safe care

Managing risk and promoting health and safety

The unit appeared to be clean, appropriately lit and well ventilated. We found most areas to be clutter free and well organised.

We observed clean utility and sluice doors wedged open throughout the unit. We also saw medication cupboards and medical gas cupboards left unlocked during our initial tour of the unit. It was felt that this could pose a potential risk to both the safety of patients and also a risk to appropriate safe storage of medication and patient identifiable information. This was raised at the time of the inspection and where possible, these were rectified immediately. We have included further details around safe medicines storage and patient information under the section on Medicines Management and Information Governance and Communications Technology.

The inspection team considered the security of new born babies on both the delivery suite and Ward 21. Although security measures were in place to ensure that babies were protected via a tagging system, we noted on occasion that staff would override the complex door access system which opened all access doors to the unit, such as during an emergency theatre transfer. During these occasions, there was no additional monitoring system in place to note who was entering and leaving the unit. We were advised that an abduction drill had taken place earlier in the year, however, we could not be assured that the issues we identified, had been considered at that time or since. We also saw that although a tagging system was in place, this was not always documented within the notes. Our concerns regarding these were 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 looked at the arrangements within the unit for accessing medical assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells. We found the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate equipment, including a defibrillator. The emergency drugs were also stored on the resuscitation emergency trolley, however, we could not be assured that regular checks were taking place on this equipment to ensure it was appropriate for use. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided within Appendix B.

There were emergency evacuation nets for the birthing pools were seen within the unit. We were assured that all staff had received appropriate training in their appropriate use in the case of emergency.

Falls prevention

We saw there was a risk assessment in place for patients within the unit as well as those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the unit were clean and tidy, the furnishings and fittings throughout the unit were generally in a good state of repair.

There was adequate hand washing and drying facilities available with posters displayed to promote the correct hand washing procedure to follow as a visual prompt for staff. We saw that personal protective equipment was available in all areas and was being used by all healthcare professionals. However, we observed poor compliance to the standards of being Bare Below the Elbow[10]. The inspection team also noted that throughout the unit, there were limited alcohol sanitiser gels available to help minimise the risk of infection of patients and visitors to the department.

We were told that an infection control audit had been carried out by the health board recently and we were shown the results of this. Compliance was seen to be good and any improvements identified were dealt with in a timely manner. We found that cleaning schedules for the unit were in place and consistently completed by midwifery staff. We also saw designated labels on equipment to signify that it was clean and ready for use. Staff explained that any concerns raised regarding infection prevention and control would be escalated to senior members of staff.

Some side rooms within the unit were available for patients use, should there be a requirement to reduce the risk of infection and help prevent infections being transferred to other patients. We were told that the birthing pools were cleaned daily and regular water testing takes place as guidance states. However, the inspection team found blood stained cables within a birthing room, this was escalated to the midwife in charge and removed immediately.

We saw sharps bins throughout the unit, however the majority had not been signed when bins were created and were seen to be wide open, which allowed for easy access to the waste stored within.

Whilst we found the general cleaning of the unit was adequate, we noted in some areas within the unit where the cleaning schedule had not been completed by the domestic cleaners. There was also little evidence of monthly cleaning audits being carried out by the health board.

[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.

Improvement needed

The health board must ensure that:

- Staff are compliant with Bare Below the Elbow standards
- Hand sanitiser gels are made available throughout the unit
- Sharps waste is stored appropriately
- All cleaning schedules and audits are appropriately completed.

Nutrition and hydration

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

Within the unit there were facilities available to purchase drinks if required. We saw patients being offered hot and cold drinks and water jugs were within easy reach. Staff on the unit had access to facilities to make toast and drinks for patients outside of core hours. Patients also told us that the food and drinks available were to a good standard.

In the patient care records we reviewed, we found that patient nutritional requirements were well documented.

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. We found inconsistencies across the unit on the daily checks of the fridge temperature at which medication was stored. This meant we could not be assured any discrepancies in temperatures were being identified and escalated.

We also noted that there were inconsistencies in the daily checking of the controlled drugs within the unit.

The inspection team 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 stored securely, to prevent unauthorised access and to uphold patient safety. Ethyl Chloride (skin refrigerant to control pain in venepuncture) was found within the birthing unit clean utility room. We also noted large quantities of lignocaine ampoules were stored within unlocked trollies on the unsecured theatre link corridor.

The inspection team reviewed the process in relation to induction of labour and found that the doctors were prescribing both PROPESS and Prostaglandins (hormones used in induction of labour to open cervix). However, we found this was being prescribed with no indication or instruction of the administration requirements, which was not in line with national guidance. Staff told us that it was presumed the midwife caring for the labouring woman would know when to use which medication. However, we felt this practice was unsafe due to the risk of incorrect or inappropriate administration.

We considered the arrangements in place for checking patient results within the triage area of the unit out of hours. We found that medical staff would not routinely chase results, however as a failsafe, staff would ask the patients to telephone the unit to establish their own results. Within the hand over meetings we attended, we found there was no structured process in place to ensure there was follow-up on previous tests carried out.

Our concerns regarding medicine storage/management and prescribing were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

We looked at a sample of medication records and saw the majority had been completed appropriately, however, we found there to be gaps in prescriptions being consistently signed and dated when prescribed and administered. We also saw inconsistencies in a pain score tool being completed on Ward 21. The health board medicines management policy was available electronically and also stored in a file within the unit areas. Staff confirmed that they knew where to locate this when required.

Pharmacy support was available to the unit and an out of hours computerised process was available for staff to check stock and availability of drugs across the hospital during these times, to ensure there were no delays in patients receiving medication. The unit also had access to a stock of take home medication, allowing patients to be discharged in a timely manner. We were told by some staff that a previous pharmacy audits had been completed with poor results seen, they also shared that learning had not been seen to take place from this.

Improvement needed

The health board must ensure that:

- Doors to medication/records rooms are securely closed to maintain safety
- Regular audits of prescription charts take place to ensure correct completion is taking place
- Learning from pharmacy audits is completed and shared with staff.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be at risk. Safeguarding training was mandatory and all staff we spoke with confirmed they had received training within the past 12 months.

There was an appointed lead safeguarding midwife for the health board who would provide support and training to staff. We were told that safeguarding training included guidance regarding female genital mutilation, domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. Formal safeguarding supervision had been recently introduced, and was mandatory for staff to attend two sessions per year. The health board recently started to roll-out the process to community based midwives, with the intention of expanding this across the rest of the service over the year.

There were appropriate procedures in place to alert staff to safeguarding concerns with regards to patients being admitted onto the unit, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

We considered the arrangements for the checking of resuscitation equipment within the unit. We found the checks on the neo-natal resuscitaire[11]and adult emergency resuscitation equipment throughout the unit were inconsistently recorded and did not demonstrate that they had been carried out on a daily basis. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B. An additional recommendation is made within the Quality of Management and Leadership section of this report, with regards to the oversight of the day to day checking of equipment.

We found that regular checks of other pieces of equipment, such as blood pressure machines, had been carried out in a consistent and regular manner.

We were informed that the original bed allocated to the triage room had broken and not been replaced. We understand that staff were using the suturing couch from the midwifery led unit which was not appropriate when patients were being seen in both areas.

Improvement needed

The health board must ensure that the triage bed is replaced to ensure that an adequate amount of equipment is available.

Effective care

Safe and clinically effective care

Due to the immediate concerns we identified during this inspection, we were not assured that patient care could always be provided in a safe and effective way. This was because of the following issues:

- Inadequate checks on emergency equipment

[11] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

- Prescribing the induction of labour medication was open to variation in interpretation
- Personal information not always protected
- Insufficient management oversight of ward activities, to ensure essential processes and procedures were being followed to support the delivery of safe and effective care.

Our concerns regarding these were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B. It was however, positive to find that staff reacted quickly and promptly to address the issues we raised.

We reviewed the training and procedures followed in reviewing Cardiotocography (CTG) [12] results of inpatients. We were informed by staff that as a result of the CTG traces being displayed centrally on the monitor in the coffee room, there was at times a tendency to review CTG traces in isolation on the monitor as opposed to at the bedside in conjunction with a review of the patient and the entire clinical picture. Staff spoke highly of the regular multidisciplinary meetings held on the delivery suite. However, we could not see evidence that this had been held for the last three weeks.

We observed staff effectively prioritising clinical need and patient care within the unit. From the patient records reviewed, it was evident that clinical need prioritisation was at the forefront in care planning. Staff who we spoke with said they were happy with the quality of care they were able to give to their patients. We saw that patients within the unit appeared comfortable and well cared for. Pain relief would be available to patients during labour. We also saw good evidence of medical assessment and treatment plans throughout the patient records reviewed.

We saw that a breastfeeding coordinator was appointed. Staff and patients confirmed that breastfeeding support was very good. However, staff told us that

[12] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

the substantial workload meant that visibility of the breastfeeding coordinator on the unit to promote breastfeeding was greatly reduced.

Improvement needed

The health board must ensure that breastfeeding support is regularly reviewed.

Quality improvement, research and innovation

A lead clinical research and improvement midwife was in place, who covered maternity services across the health board.

We were told that projects to support education in growth assessment protocol and gestational related optimal weight (GAP and GROW)[13], epilepsy in patients, and the full review of documentation and creation of care pathways across the unit had been recent projects completed. We were told of plans to appoint innovation champion midwives across the service, who would be encouraged to get involved and support the wider team in service and research projects.

The health board maternity practice development midwife was seen to carry out continued promotion of practical obstetric and multi-professional training (PROMPT)[14], which had been successfully implemented within the maternity services across the health board.

Information governance and communications technology

We considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations (2018) within

[13] GAP – Growth assessment protocol - GROW – Gestation related optimal weight (A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[14] PROMPT - Practical Obstetric and Multi-Professional Training. Its importance is to train teams to be teams within their working environment.

the unit. We found patient information within the delivery unit was not being securely managed or stored, to prevent unauthorised access and to uphold patient confidentiality. This included trollies containing multiple patient records that were unlocked and patient identifiable information left out on a desk at the nurse's station. These were all located within a patient/visitors assessable corridor. Our concerns regarding these 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 procedures. However, there were a number of these found to be out of date and requiring review.

We found that the unit was using a maternity dashboard. This is an electronic tool to monitor the clinical performance and governance of their services. This also helps to identify patient safety issues so that timely and appropriate action can be taken to ensure high quality care. We were told that all staff within the unit had their own computer access login ensuring information governance was maintained. We were however, told by staff that there was no access to the clinical portal which is where testing results are located. This was felt to have a detrimental effect on care given, delay in care planning and delays in efficiently discharging.

Improvement needed

The health board must ensure that:

- Policies and procedures are reviewed and updated within appropriate timescales
- Staff have timely access test results via the appropriate information system.

Record keeping

Overall, we found the standard of record keeping to be adequate with care plans well documented between multidisciplinary teams. However, some patient records we reviewed were disorganised and difficult to navigate. We saw appropriate observations charts and care pathway bundles being used. However, whilst we saw that preventative measures had been put in place to prevent

Venous Thromboembolism (VTE)[15] for patients on the on the unit, risk assessments had not been documented to support the reason why.

We also saw inconsistencies across the medical health records reviewed with gaps in areas such as signature and General Medical Council registration number documentation.

Improvement needed

The health board must ensure that patient records are fully reflective of the care and treatment provided and in line with standards of professional record keeping. This should also include being able to identify all clinical carers with printed names and GMC numbers.

[15] https://www.nice.org.uk/guidance/ng89/chapter/Recommendations#risk-assessment

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.

Specialist midwives were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

Staff reported that there was good multidisciplinary team working and we saw evidence to support this.

We found evidence of good leadership and management amongst midwifery and medical teams within the unit.

However, further work on audit findings is required.

We also found gaps in training, learning and staffing which required further review.

Governance, leadership and accountability

We saw the service held a number of regular meetings to improve services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, monthly audit review meeting and obstetric clinical review of incident meeting. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums and a weekly multidisciplinary meeting.

We found there was audit activity taking place which was being monitored and presented in appropriate quality, safety and risk meetings and forums. However, we found from speaking with staff, that the audit process required improvement in relation to follow up work identified through audit activity, with more work required to strengthen the assurance in this area.

As previously discussed, a monthly maternity dashboard was produced, which included information in relation to the whole health board, but broken down to each hospital. This provided information with regards to the clinical activity,

induction of labour, and clinical indicators and incidents. The dashboard was rated red, amber and green depending upon the level of risk associated with the numbers and figures.

In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[16] and Each Baby Counts[17] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies, such as MBRRACE and ongoing work takes place to ensure the unit is in line with the recommendations made.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were never dealt with in a punitive manner. However, some staff we spoke to advised that they had not all received Datix (electronic incident management system) training and were not aware of when to escalate concerns.

Monthly risk and governance meetings are held across all three sites of the health board where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. The lead governance midwife presented themes and trends to this meeting, with the view of highlighting any areas of practice, which were in need of addressing across the heath board. However, staff we spoke with highlighted inconsistencies in how lessons were learnt and shared across teams. We did however see evidence of an informative

[16] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.

[17] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

monthly newsletter which was seen to be a good means to provide positive feedback to staff and to highlight where good practice had been evident.

We were assured that the internal risk register was monitored and acted upon when required.

Daily leadership within the unit was advised by staff to be very good. However, staff advised that although they knew the managers would be at the end of the telephone if needed, we were told that there was little visibility of them on the unit.

We saw good work carried out by the consultant midwife to achieve expert practice, such as development in user engagement, strategic service development and creation of many training initiatives to increase learning and development.

Improvement needed

The health board must ensure that:

- Learning and follow-up actions identified from concerns, audits and other improvement activity is consistently undertaken and shared
- All appropriate staff receive training in how and when to report incidents via Datix
- Consideration is given to improving the visibility of senior staff within the unit.

Staff and resources

Workforce

We distributed over thirty staff questionnaires during the inspection, however only five were completed and returned.

All staff we spoke with said that the leadership and support, personally and in a work perspective, is excellent from direct line managers. Strong team working was seen to be encouraged by all senior managers. Staff we spoke with and those who completed questionnaires confirmed this.

We were told by senior managers that midwifery rotas were well managed within the unit. If there were any shortages of staff cover, we were told that community midwives would be called in. Senior managers also advised they would also step

in to cover when required. However, some of the staff we spoke with told us that there were regularly issues with midwifery staffing coverage. We were told that there was a large amount of long term sickness and vacancies, although these appeared to be managed well. We saw there were escalation processes in place for use in times of staff shortage and all staff we spoke with were aware of how to locate the policy and how to escalate issues. Following conversations regarding temporary staffing, we were not assured that the working time directive[18] was effectively being monitored, where staff were working above and beyond their core working hours.

We saw evidence of a robust induction programme in place for midwifery staff, and staff advised that these were found to be of benefit when commencing in role. However, induction packs were not available for new medical staff, although we saw that ongoing training and mentorship for medical staff was in place. Medical staff we spoke with confirmed that the training, support and guidance was of a very high standard. This was also seen to be the case within other staff interviews conducted. We were also told by midwifery staff that the preceptorship programme required improvement to ensure new staff felt supported.

We found that there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training, such as health and safety, fire safety, infection prevention and safeguarding, was predominately completed on-line and was monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire, to ensure re-training is completed within appropriate timescales. However, upon reviewing training records and speaking with staff, we saw training in CTG was inconsistent and had a poor compliance rate.

The service holds three mandatory maternity related study days across the year. One of the days is PROMPT training, which is a multidisciplinary training event, used to encourage multidisciplinary working in emergency situations. All staff we spoke with said they attend this training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that

[18] A law in which staff are not allowed to work more than 48 hours in a working week to maintain staff safety and wellbeing.

regular training was taking place. This was also confirmed in the staff questionnaires received.

The health board had a lead midwife for practice education/practice facilitation, and part of their role was to monitor compliance with training across the year. Staff are required to book themselves onto the relevant training days and attendance is reported to the senior teams.

Clinical supervisors for midwives were in place across the health board and were described as being highly regarded. Their roles were to provide support and professional supervision to midwifery staff. There is a national target[19] to make sure that supervisors meet with midwives for four hours each year. The health board monitor compliance with this target during the previous financial year and were continuing this on an ongoing basis.

Staff we spoke with told us that they have regular appraisals and they see them as positive meetings to increase continuous professional development, which was confirmed in the compliance data seen.

We saw a Greatix board (electronic database for good practice/care) within the staff area of the unit which was regularly updated. We also noted a board displayed which announced the 'midwife of the month' which we found to be very positive.

We found that there was a good level of support in place from the specialist lead midwives who were knowledgeable about their specialist roles. These leads provide support and guidance through study days, supervision sessions and meetings with staff as and when required.

We were told there were nursery nurses employed within the services and we also saw that maternity support workers were encouraged to develop their skills to the next level in qualification. This would mean more support could be given to the midwives and new mothers in areas, such as breastfeeding, bathing and general care needs.

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[19] https://gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf

Improvement needed

The health board must ensure that:

- The midwifery staffing is reviewed to ensure safe staffing is met
- Midwifery preceptorship is reviewed
- CTG training compliance is improved.

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

Service: Prince of Wales Hospital

Area: Maternity Services

Date of Inspection: 4 – 6 November 2019

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
N/A			

Appendix B – Immediate improvement plan

Hospital Inspection: Immediate improvement plan
Service: Cwm Taf Morgannwg University Health Board
Area: Prince Charles Hospital - Maternity Services Unit
Date of Inspection: 4 – 6 November 2019

Delivery of safe and effective care				
Improvement needed	**Regulation/ 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 and adult emergency resuscitation equipment is carried out on a daily basis and in line with the health board's policy to ensure it is safe for use.	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment	Immediate feedback of the findings & expectation of safety checking was shared with the staff via a safety briefing. It has been reinforced to the maternity staff via a safety briefing that the checking of the neonatal trollies is	Head of Midwifery Head of Midwifery	Completed 05/11/2019 Completed 05/11/2019

	and Diagnostic Systems	their responsibility. This has been added to the daily checking books. Monitoring of these actions will be via the assurance audits undertaken by the operational leads for each of the areas.	Operational lead midwives	Completed 12/11/2019
The health board is required to provide HIW with details of the action it will take to ensure that: Medication is stored safely and securely at all times.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	Immediate action was to safely store the emergency drugs prepared for the obstetric theatre. The need to safely store emergency medications in theatre areas was communicated via a safety briefing. Compliance with the recommendation is being monitored via the assurance audits. The trolley which has drugs stored in it for epidural procedures is now being securely stored in the locked clinical treatment room on the labour ward. Monitoring of the safe storage of the trolley when not in use by the	Deputy Head of Midwifery Head of Midwifery Intrapartum lead midwife Head of Midwifery	Completed 05/11/2019 Completed 05/11/2019 Completed 12/11/2019 Completed 05/11/2019

		anaesthetist is being undertaken by the labour ward coordinators	Labour ward coordinator	Completed 12/11/2019
The health board is required to provide HIW with details of the action it will take to ensure that: Checks of controlled drugs are maintained in line with policy at all times.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	Staff were advised of the requirement to check controlled drugs on each handover of shift via the safety briefing. Monitoring of compliance will be undertaken via the assurance audits by the operational leads	Head of Midwifery Operational Leads	Completed 05/11/2019 Completed 12/11/2019
The health board is required to provide HIW with details of the action it will take to ensure that: Medicines are stored at appropriate temperatures and regular checks of medicine fridge temperatures are maintained in line with the health board's policy.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	All drug fridges in the maternity unit now have a checking sheet attached to the fridge which records the temperatures as well as documenting actions taken when the temperatures are not within the agreed limits. This requirement was communicated to all staff via the safety briefing issued the day HIW shared the immediate safety actions. Monitoring of the checking is now via the assurance audits	Head of Midwifery & Operational lead midwives Operational lead midwives	Completed 05/11/2019 Completed 12/11/2019

The health board must provide HIW with details of the action it will take to ensure that: The prescription of induction medication is reviewed, to minimise the risk of administration errors.	3.1 Safe and Clinically Effective Care	Communication sent out to all staff via the safety briefing regarding the planned admission of women for induction of labour. Medication charts are being completed in advance of admission with Propess and Prostin. Guidelines states give “either or” based on the Bishop Score on admission. Guidance has been sent to staff requesting that medication charts should clearly state administration of either Propess or Prostin. A new prescription sticker has been developed and placed on the front of the medication chart in the comments section indicating administration of Propess or Prostin based on Bishop Score.	Head of Midwifery Deputy Head Of Midwifery	Completed 05/11/2019 Completed 05/11/2019
The health board must provide HIW with details of the action it will take to ensure that:	3.1 Safe and Clinically Effective Care	The unit has developed a system for retrieving results of any women who attend triage during pregnancy. This systems requires the midwife to	Intrapartum Lead Midwife	Completed 07/11/2019

There is an appropriate system in place to ensure test results are reviewed for patients seen in out of hours triage, to minimise the risk to patient safety.		record the details of the woman and tests taken. The responsibility of the follow up is given to the triage midwife to obtain results – and document the action taken. The monitoring of this new system is being undertaken by the intrapartum lead midwife and operational midwife for labour ward.	Intrapartum Lead Midwife	12/11/2019
The health board must provide HIW with details of the action it will take to ensure that: The process for the review of CTG results is carried out in a timely manner with appropriate governance assurance to minimise the risk to patient safety.	3.1 Safe and Clinically Effective Care	Staff were advised of the findings from the review team and requested to ensure all clinical reviews of CTG's are undertaken in the room with the woman where they will also have full access to the maternity records and clinical history. Clinical management plans must be documented in the maternity records and any significant event should be annotated contemporaneously on the CTG paper recording (i.e. '*epidural in progress*') This has been communicated via a safety brief	Head of Midwifery & Clinical Director Head of Midwifery & Clinical Director	Completed 12/11/2019 Completed 12/11/2019

		Monitoring of this practice will be via the clinical review meetings to ensure compliance.	Governance lead midwife & Lead obstetrician for labour ward	Completed 12/11/2019
The health board must provide HIW with details of the action it will take to ensure that: Patient information is stored securely at all times to maintain patient confidentiality and prevent unauthorised access.	3.5 Record Keeping	Staff have been reminded of the requirement to keep hospital records safe and secure via the safety briefing. The notes trolley on the ward which could not be locked was repaired. Notes stored under the nursing station on the ward awaiting the community postnatal record to be filed have been moved to a secure area.	Head of Midwifery Ward sister Ward sister	Completed 05/11/2019 Completed 05/11/2019 Completed 05/11/2019
The health board is required to provide HIW with details of the action it will take to ensure that:	2.1 Managing Risk and Promoting Health and Safety	Communication has been sent to staff to remind them of the risk associated with the need to override the security doors in an emergency situation. This has also included warning staff to	Head of Midwifery	Completed 12/11/2019

If the security system on doors to the unit are overridden, measures are in place to ensure the risk of baby abduction is mitigated.	2.7 Safeguarding Children and Safeguarding Adults at Risk	only use this system for the most serious of emergencies and not as a means of opening the door in a less urgent clinical situation. When the doors are overridden staff must check that no parents or visitors are near the doors with a baby and staff are physically at the doors during this time to prevent any easy access into or out of the ward. Plans are in place to review the current security door system and consider the option to have a single locked door rather than the double door system in use. This will require a full review of the risks associated with removing the second door. The estates team have been requested to undertake a review with a plan to install security cameras at both entrances.	Head of Midwifery Head of Midwifery/ Directorate Manager / Head of Estates & Security Head of Midwifery	Completed 12/11/2019 Request actioned 12/11/2019 Request actioned 12/11/2019

Service Representative:

Name (print):	**Greg Dix**
Role:	**Executive Director of Nursing, Midwifery and Patient Care**
Date:	**14 November 2019**

Appendix C – Improvement plan

Service: Cwm Taf Morgannwg University Health Board

Area: Prince Charles Hospital - Maternity Services Unit

Date of Inspection: 4 – 6 November 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.	3.2 Communicating Effectively	• Information on smoking cessation services has been displayed in the maternity unit	Public Health Midwife	31/01/2020
The health board must ensure that bed allocation within the antenatal and postnatal wards is reviewed to ensure that patient dignity is maintained.	4.1 Dignified Care	• The maternity ward has the appropriate space between the beds and there are curtains around all the beds. • Staff are to be reminded to use the ward office or a single cubicle if available to have confidential discussions with women	Ward Sister Ward Sister	Completed 20/11/2019 Completed 10/01/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Monitoring of women's experience of the ward to continue through the weekly surveys. Any feedback from women in relation to concerns about dignity and privacy to be reported immediately.	PALs Team	Completed 10/01/2020
The health board must ensure that the process and structure of handover meetings are reviewed and improved.	3.1 Safe and Clinically Effective Care	• Immediate safety brief sent to all clinicians reminding them of the requirements on them during handover. • Intrapartum lead midwife to undertake observational audits of the handover document the findings and provide feedback to the teams.	Head of Midwifery & Clinical Director Intrapartum Lead Midwife	Completed 5/11/2019 31/01/2020
The health board must ensure that information is clearly displayed and readily available about how patients and families/carer can raise a concern about their care.	3.2 Communicating Effectively	• Information requested to be displayed in the maternity unit.	Women's Experience Midwife	31/01/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	3.2 Communicating Effectively	• Information requested to be displayed in the maternity unit.	Women's Experience Midwife	31/01/2020
Delivery of safe and effective care				
The health board must ensure that a review of bare below the elbow is carried out.	2.1 Managing Risk and Promoting Health and Safety	• Request for the frequency of infection control and 'bare below the elbow' audits to be increased to monitor compliance. • CMO guidance to medical staff on 'bare below the elbow resent to reinforce the requirements	Ward Sister Head of Midwifery	Completed 10/01/2020 Completed 10/01/2020
The health board must ensure that hand sanitiser gels are made available throughout the unit.	2.1 Managing Risk and Promoting Health and Safety	• Additional hand sanitisers gels to be placed in all the clinical areas	Ward Sisters	31/01/2020
The health board must ensure that sharps waste is stored appropriately.	2.1 Managing Risk and Promoting Health and Safety	• Staff to be reminded of the requirement for safe management of sharps. (undertaken as an	Head of Midwifery	Completed 5/11/2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		immediate action at the time of the visit) • Ward sisters to monitor compliance of safe storage of sharps via the monthly assurance audits	Ward Sisters	Completed 10/01/2020
The health board must ensure that all cleaning schedules and audits are appropriately completed.	2.1 Managing Risk and Promoting Health and Safety	• The Hotel services department have been requested to confirm dates of cleaning audits and ensure cleaning score are sent to the Directorate. • Monitoring of the cleaning audits and scores will be via the Directorate Infection Prevention & Control meeting	Hotel Services Deputy Head of Midwifery	Completed 10/01/2020 21/01/2020
The health board must ensure that doors to medication/records rooms are securely closed to maintain safety.	2.1 Managing Risk and Promoting Health and Safety	• Staff to be reminded of the requirement for safe management medicines which includes doors being securely closed. • Monitoring of this action will be via the assurance audits	Head of Midwifery Ward Sisters	Completed 10/01/2020 31/01/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that regular audits of prescription charts take place to ensure correct completion is taking place.	2.1 Managing Risk and Promoting Health and Safety	• Audits of prescription charts are being undertaken via the monthly assurance audits	Ward Sisters	Completed 10/01/2020
The health board must ensure that learning from pharmacy audits is completed and shared with staff.	2.1 Managing Risk and Promoting Health and Safety 3.2 Communicating Effectively	• Findings of the audits are to be feedback to staff at the time of the audits if remedial action required it must be completed at the time. • Regular feedback of the audits will be via the risk newsletter	Ward Sisters Risk Midwife	28/02/2020 28/02/2020
The health board must ensure that the triage bed is replaced to ensure that an adequate amount of equipment is available.	3.1 Safe and Clinically Effective Care	• Replacement beds have been ordered by the department • Staff have been requested to ensure any damaged or broken equipment requiring replacement is escalated to the senior midwife in order for replacements to be sought immediately	Ward Sister	Completed 05/11/2019 Completed 10/01/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that breast feeding support is regularly reviewed.	3.1 Safe and Clinically Effective Care	• The infant feeding coordinator to review the current support for breast feeding. • Additional resources for breast feeding support in the community has been identified. • Baby friendly undertook an additional review of the accreditation status of PCH and supported the ongoing BFI accreditation status. Reassessment will be undertaken in November 2020 and work to maintain accreditation is underway.	Infant Feeding Coordinator Head of Midwifery Infant Feeding Coordinator	Completed 05/12/2019 Completed 05/12/2019 Completed 31/07/2019
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	3.1 Safe and Clinically Effective Care	• The maternity services have established clinical forums which have allocated guidelines to manage. The HB will ensure that all clinical guidelines are updated and merged with Princess of Wales unit by end March 2020	Head of Midwifery & Clinical Director	31/03/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that staff have timely access test results via the appropriate information system.	3.1 Safe and Clinically Effective Care 3.4 Information Governance and Communication Technology	• The unit has developed a system for retrieving results of any women who attend triage during pregnancy. This systems requires the midwife to record the details of the woman and tests taken. The responsibility of the follow up is given to the triage midwife to obtain results – and document the action taken. • The monitoring of this new system is being undertaken by the intrapartum lead midwife and operational midwife for labour ward.	Intrapartum Lead Midwife Intrapartum Lead Midwife	Completed 07/11/2019 31/01/2020
The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping regarding being able to identify all clinical carers with printed names and GMC numbers.	3.5 Record Keeping	• Staff reminded of their professional requirements to accurately record care and document their names fully.	Head of Midwifery & Clinical Director	Completed 10/01/2020 31/02/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Monitoring of the standards of documentation will be through the annual record keeping audits	Clinical supervisors of Midwives	
Quality of management and leadership				
The health board must ensure that learning and follow-up actions identified from concerns, audits and other improvements activity is consistently undertaken and shared.	3.1 Safe and Clinically Effective Care	• The Directorate to continue sharing learning from concerns/ audits and other improvement initiatives at the professional forums and governance days. • To Directorate to continue providing feedback via the risk newsletter	Head of Midwifery Clinical Director & Directorate Manager	Completed 05/11/2019 Completed 10/01/2020
The health board must ensure that all staff receive training in how and when to report incidents via Datix.	3.4 Information Governance and Communication Technology	• Annual training provided to staff on datix and incident reporting. This includes the maternity trigger list and information on how to access the feedback sent.	Risk Midwife	31/03/2020
The health board must ensure that consideration is given to improving the visabilitty of senior staff within the unit.	7.1 Workforce	• Senior midwifery team aim to be visible in the unit when not in the unit – staff are to be informed of	Head of Midwifery	Completed 10/01/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		who is available for them to contact.		
The health board must ensure that the midwifery staffing is reviewed to ensure safe staffing is met.	3.1 Safe and Clinically Effective Care 7.1 Workforce	• Birth rate + assessment completed and staffing requirements based on the service demands have been calculated.	Head of Midwifery	Completed 07/01/2020
The health board must ensure that midwifery preceptorship is reviewed.	3.1 Safe and Clinically Effective Care 7.1 Workforce	• The practice development midwives to undertake a review of the current preceptorship programme involving the newly qualified midwives to ensure their views and needs are included in the programme.	Practice Development Midwives	28/02/2020
The health board must ensure that CTG training compliance is improved.	3.1 Safe and Clinically Effective Care 7.1 Workforce	• CTG training sessions to be circulated to all staff yet to complete. • Weekly monitoring of compliance discussed at monitoring meetings with WG	Head Of Midwifery & Clinical Director	Completed 07/01/2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• The service aims to complete all training by March 2020		31/03/2020

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): **Jane Phillips**

Job role: **Head of Midwifery**

Date: **10/01/2020**